DOCUMENT RESUME

ED 060 447	AC 012 466
TITLE	Proceedings [of the] Second National Conference of State Medical Association Representatives on Continuing Medical Education, October 13-15, 1970.
INSTITUTION	American Medical Association, Chicago, Ill.
PUB DATE	Oct 70
NOTE	112p.
EDRS PRICE	MF-$0.65 HC-$6.58
DESCRIPTORS	*Conferences; Evaluation; Financial Support; Institutes (Training Programs); Learning Motivation; Medical Associations; *Medical Education; *Physicians; *Professional Continuing Education; Program Content; *State Programs

ABSTRACT

The responsibility of organized medicine in the area of continuing education was the focus of this conference. Papers presented at the conference and summaries of workshop discussion groups comprise this document. The papers are: The Purpose of the Conference; Maintenance of Physician Competence; Motivation for Continuing Medical Education; Peer Review and Evaluation as Educational Tools; Regionalization and Continuing Medical Education; Continuing Medical Education--Issues and Answers; Developing and Teaching Faculty at Community Hospitals; Self-Assessment and the Professional Society; The Postgraduate Medical Institute Program in Continuing Medical Education; the MIST Program; Clinical Traineeships; and The Physical Profile Program for Continuing Medical Education. The workshops were on motivation, evaluation, organization and methods, financing, and the role of the State medical association in continuing medical education. A list of participants is provided. (DB)

U.S. DEPARTMENT OF HEALTH,
EDUCATION & WELFARE
OFFICE OF EDUCATION
THIS DOCUMENT HAS BEEN REPRODUCED EXACTLY AS RECEIVED FROM THE PERSON OR ORGANIZATION ORIGINATING IT. POINTS OF VIEW OR OPINIONS STATED DO NOT NECESSARILY REPRESENT OFFICIAL OFFICE OF EDUCATION POSITION OR POLICY.

ED 060447

AMERICAN MEDICAL ASSOCIATION

PROCEEDINGS

SECOND NATIONAL CONFERENCE OF STATE MEDICAL ASSOCIATION REPRESENTATIVES ON CONTINUING MEDICAL EDUCATION

AMBASSADOR HOTELS
CHICAGO, ILLINOIS
OCTOBER 13-15, 1970

AC012466

Department of Continuing Medical Education, Division of Medical Education, American Medical Association, 535 North Dearborn Street, Chicago, Illinois 60610

4/12/72

AMERICAN MEDICAL ASSOCIATION

PROCEEDINGS

SECOND NATIONAL CONFERENCE OF STATE MEDICAL ASSOCIATION REPRESENTATIVES ON CONTINUING MEDICAL EDUCATION

AMBASSADOR HOTELS
CHICAGO, ILLINOIS
OCTOBER 13-15, 1970

Department of Continuing Medical Education, Division of Medical Education,
American Medical Association, 535 North Dearborn Street, Chicago, Illinois 60610

TABLE OF CONTENTS

Page

Program for the Meeting 1

The Purpose of the Conference 3
Donald W. Petit, M.D.

Maintenance of Physician Competence 5
Francis C. Coleman, M.D.

Motivation for Continuing Medical Education 14
C. John Tupper, M.D.

Peer Review and Evaluation as Educational Tools 18
Robert L. Evans, M.D.

Regionalization and Continuing Medical Education ... 35
E. Grey Dimond, M.D.

Continuing Medical Education - Issues and Answers ... 39
James Z. Appel, M.D.

Developing and Teaching Faculty at Community Hospitals 49
Max Michael, Jr., M.D.

Self-Assessment and the Professional Society 53
William O. Robertson, M.D.

The Postgraduate Medical Institute Program in Continuing Medical Education 56
Norman S. Stearns, M.D.

The MIST Program 61
Margaret S. Klapper, M.D.

Clinical Traineeships 74
Ephraim T. Lisansky, M.D.

The Physician Profile Program for Continuing Medical Education 82
Sigurd E. Sivertson, M.D.

Summaries of Workshop Discussion Groups
- Workshop on Motivation 92
- Workshop on Evaluation 96
- Workshop on Organization and Methods 98
- Workshop on Financing 100
- Workshop on the Role of the State Medical Association in Continuing Medical Education 103

List of Participants at the Conference 105

PROGRAM

TUESDAY, OCTOBER 13, 1970

OPENING PLENARY SESSION

1.	The Purpose of the Conference	*Donald W. Petit*
2.	Maintenance of Physician Competence	*Francis C. Coleman*
3.	Motivation for Continuing Medical Education	*C. John Tupper*
4.	Peer Review and Evaluation as Educational Tools	*Robert L. Evans*
5.	Regionalization and Continuing Medical Education	*E. Grey Dimond*
6.	Continuing Medical Education - Issues and Answers	*James Z. Appel*

Workshop Discussion Groups on the following subjects:

1. Motivation
2. Evaluation
3. Organization and Methods
4. Financing
5. The Role of the State Medical Association in Continuing Medical Education

WEDNESDAY, OCTOBER 14, 1970

GENERAL SESSION

1. Developing a Teaching Faculty at Community Hospitals	*Max Michael, Jr.*
2. Self-Assessment and the Professional Society	*William O. Robertson*
3. The Postgraduate Medical Institute Program in Continuing Medical Education	*Norman S. Stearns*

Continuation of Workshop Discussion Groups

GENERAL SESSION

1. The MIST Program	*Margaret S. Klapper*
2. Clinical Traineeships	*Ephraim T. Lisansky*
3. The Physician Profile Program for Continuing Medical Education	*Sigurd E. Sivertson*

Continuation of Workshop Discussion Groups

Each participant is assigned to two Workshop Discussion Groups and may choose the third.

THURSDAY, OCTOBER 15, 1970

1. Reports from Workshop Discussion Groups
2. General Discussion
3. Summary
4. Adjournment

THE PURPOSE OF THE CONFERENCE

DONALD W. PETIT, M.D.

I have been given the task of describing the purpose of this Conference to you. It is almost two years since the first Conference was held in November 1968. At that time - for the very first time - we brought together individuals representing state medical associations who had a deep interest in continuing education and there was a start of conversation and dialogue about the role of the state medical association in continuing education and an outlining of some of the problems that were to be faced. The Physician's Recognition Award was just beginning to be implemented. Problems of financing continuing education and budget priorities for continuing education were discussed. We were given an interesting preview in 1968 of activities that were starting in the Oregon Medical Association, the Michigan Medical Association, as well as the California Medical Association.

Now we come together again. I would like to identify this group as a working group. One has only to look at the program in the evening sessions to appreciate that! But more importantly, we have the ingredients here of a force that not only can discuss and adopt, but can implement measures that seem feasible. I think the time has come in continuing education to accept some of the many challenges that the field contains and to work on them in a responsible way. Organized medicine has crossed, or has passed, an important marker in continuing education with the development of recognition awards and serious consideration by many associations of participation in continuing education as a requirement for membership in such associations. Methods for accrediting continuing education are slowly evolving. We are in an embryonic state, but a growing one, for developing mechanisms to determine the needs for continuing education.

I would like to feel that all of us here take the responsibilities of continuing education seriously, and earnestly, and have a personal commitment to carry on with plans that come from meetings of this type. I would like to list for you some of the important questions that I think we must consider at this meeting and that I hope will come up in your workshops and from which we can achieve a sense of direction and movement. These questions are not listed necessarily in their order of importance but as they come to mind:

1. Should we make membership in organized medicine contingent on documented participation in continuing education? The implications behind this question are many and I think deserve very serious reflection.

2. How can we best relate continuing education to better care? Under this question might come the vexing one of the team care concept - who does what? Who

learns what in order to do what? How should we weave the team care, the interdisciplinary actions and reactions implicit in this, into our continuing education programs?

3. What sources of funding should we generate? Can this entire effort be carried on tuition fees? Should we attempt to utilize federal funds; state funds; local funds? How can a significant continuing education effort be launched? Can it be done almost entirely by voluntary efforts?

4. How do we determine education needs? Should we make mandatory medical audit procedures in community hospitals? Should we encourage all of our membership to participate in appropriate self-assessment examinations? Should we utilize morbidity and mortality information? Should we seek data from patients and sources other than providers, to determine educational needs?

5. What resources and organizations can best serve the purpose? How can the communication needs for continuing education be best utilized? How can the library needs be utilized? What can we do as consumers of a very necessary service to implement concepts such as the Lister Hill Biomedical Communications Center? What role should we encourage the university and the hospitals to play? What relationships should our state associations take to state governmental bodies in terms of funding continuing education?

These are but a few of the important questions that I see and think about when one considers this large area of continuing education. We come here as a working group, under the auspices of the American Medical Association, but all of us represent many other groups. Some come from university settings, some come from regional medical programs, some come for the Association of American Medical Colleges, some from specialty societies. A vast network that needs to coordinate into a maximally efficient body. This group is primarily physicians. Should future meetings bring in other groups?

I would close by again stating my hope that you will consider yourselves as a working body which is capable and has the means to implement many of the decisions that are reached.

MAINTENANCE OF PHYSICIAN COMPETENCE

FRANCIS C. COLEMAN, M.D.

I appreciate the opportunity to participate in your meeting, and to share with you some thoughts about maintaining professional competence. Unprecedented advances in the science and technology of medicine in the past two decades have greatly increased the ability to prevent, discover, and cure illness. At the same time, such advances have heightened medicine's longstanding concern with assuring that day-to-day care of patients fully utilizes these new scientific and technological advances. The extensive work in continuing medical education conducted by the Council on Medical Education, including this Conference and its predecessor, gives ample evidence of such concern.

This concern is being shared to an increasing degree by leaders outside the field of medicine as well. In its 1967 Report, the President's National Advisory Commission on Health Manpower noted that in the past "reliance on quality controls in formal education and licensure have been the primary means of assuring that physicians use the best techniques and information available. But with the increasing pace of medical advances, these 'one-time' controls are not enough; the physician's education must be continued as long as he practices." As a way of assuring continuing physician participation in education programs the President's Commission recommended that: "Professional societies and state governments should explore the possibility of periodic relicensing of physicians and other health professionals. Relicensure should be granted either upon certification of acceptable performance in continuing education programs or upon the basis of challenge examinations in the practitioner's specialty."

The Council on Health Manpower and its Committee on Certification, Registration and Licensure, on which I sit, have given careful consideration to this recommendation as well as to other suggested incentives toward continued physician competence. In a report adopted by the House of Delegates in June, 1969, the Council recommended in essence that a physician relicensure program not be considered at this time, but that alternative mechanisms for stimulating continued physician participation in programs for maintaining competence, developed from within the medical profession, be utilized to the fullest. In my remarks today, I would like to do two things: first, I would like to review briefly the current methods through which physicians have the opportunity to maintain and improve clinical competence: their potentials and areas for improvement: and second, I would like to discuss the different mechanisms or incentives for encouraging physicians to participate in these methods for maintaining competence and make some suggestions as to those which should receive further emphasis.

Approaches to maintaining clinical competence can be grouped under two general headings; continuing education programs, and medical care evaluation through practice observation. The first - continuing education - is, of course, a major responsibility of the Council on Medical Education, which through its Advisory Committee on Continuing Medical Education, identifies important needs and problems in continuing medical education and recommends action to meet such needs. A yearly Council report, titled "Continuing Education Courses for Physicians" identifies all such programs offered that year by location and sponsorship, specialty area, enrollments, and other factors.

The most recent issue of this report, covering the 1970-1971 academic year, shows that over 2,300 individual continuing education courses were offered to physicians. Even more impressive is the fact that the number of continuing education courses offered has increased by an annual increment of roughly 10% over the past nine years. In 1961-1962, 1,105 courses were reported, compared with the 2,319 offered in 1970-1971. Enrollments have also shown a steady increase. In the years 1961-1962, 57,500 registrations were reported from courses conducted at medical schools. Attendance figures for 1969-1970 (the latest year available) show 181,636 registrations at medical schools, an increase of 315%. During this same eight-year period, the total number of physicians increased only 25%; thus the proportion of all physicians involved in medical school-based continuing education has also increased significantly.

It seems generally agreed that perhaps the major issue bearing on the adequacy of continuing education programs in maintaining clinical competence is that of relevance to the individual medical practice.

Fifty percent of the courses offered in 1969-1970 did not stipulate a maximum class size. The average size of the classes given in medical schools is approximately 120. Planning course content which would be relevant to the needs of all enrollees in a class of this size is of course difficult. Too, the traditional lecture setting is not particularly conducive to the type of individualized problem-solving interchange which can be important in any successful educational process. Finally, because the majority of current continuing education programs lack a feedback or evaluation mechanism, it is difficult to assess the degree to which they actually assist in improving competence.

Another major channel through which continuing education takes place is of course the professional journal. A recent survey conducted in the states of Washington, Oregon, and Idaho, indicates that many physicians rely heavily on reading of scientific publications to keep their knowledge current. When asked to indicate the "best routes for transmitting useful information", physician respondents ranked the reading of medical journals second to formalized continuing education courses. Again, however, there is no method by which the knowledge gained in such activity may be assessed.

The foregoing is in no way intended to downgrade the value of continuing education programs in improving competence, but rather to re-emphasize the need to align format, timing and content of such programs as closely as possible to the actual needs of current medical practice. The Council on Medical Education is a leader in continuing efforts to make this constantly increasing fund of new scientific and technological information more logically organized, immediately accessible and meaningful to the physician in practice, through expanded use of automated data processing, experimentation in methodology and timing of educational programs, and continuing feedback from the real world of medical practice as to educational priorities. Meriting strong endorsement is the experimentation currently underway in integrating medical practice and continuing medical education, through the development of biomedical communications networks enabling an "on-line" approach to problem identification and solution at both clinical and educational levels simultaneously, and similar techniques which allow the practicing physician to both "diagnose" and "treat" his specific educational lacks. Since 1964, the AMA Council on Medical Education has carried out an accreditation program for institutions and organizations conducting continuing education courses. As of September, 1970, 86 institutions and/or organizations had formally been accredited by the Council on Medical Education. This accreditation program has been and will continue to be a powerful influence toward improving the quality of continuing education.

The second major approach to maintaining and improving clinical competence is through medical care evaluation and peer review of performance. Peer review functions have traditionally been based in the medical care institution as a responsibility of the medical staff, encompassing such activities as medical, surgical and obstetrical audit, including tissue and necropsy review, pathological and medical care appraisal conferences, clinical rounds and, more recently, utilization review on a sample or other basis of admissions, lengths of stay and services provided. Over the years there has been consistent movement toward strengthening and enhancing the educational component of such activities and toward improving the mechanisms for medical staff-surveillance. In a 1966 report on Utilization Review Requirements under Medicare, for example, the AMA Council on Medical Service pointed out that "utilization study, unrelated to extended-stay review, is important to foster as an educational hospital staff project and as a valuable mechanism for quality control". Most recently - in April, 1970 - the Joint Commission on Accreditation of Hospitals approved revised standards for accreditation of hospitals. The portion of these standards pertaining to the medical staff specify the responsibilities and duties of the staff in medical care evaluation, and are designed to insure (a) continuing review of each staff member's clinical activities by his peers, and (b) continued participation by all staff members in evaluation of the clinical practice that exists within the hospital, including establishment of criteria upon which to base such evaluation. This regular interface and discussion with professional peers of specific clinical problems and treatment modalities is possibly unequaled as a method for improving clinical competence. In addition, the revised Joint Commission standards specify for the first time that "the medical staff provide a continuing program of professional education, or give evidence of participation in such a program" by its members. The educational program should include hospital-based activities as well as educational opportunities available outside of the hospital. The standards encourage full utilization of results from the medical care evaluation process in the in-hospital education program.

A certain minority of practicing physicians, of course, may not be affiliated with a hospital. A considerable number of state and local medical societies have seen a need for extra-institutional peer review mechanisms, and are establishing or exploring the establishment of such a mechanism for their membership. Most such programs at this point, however, focus primarily on need for and duration of services, reasonableness of charges and similar questions of a claims review nature, and it is fair to say that the educational value of these programs is more potential than actual at this time. A number of groups, notably the Council on Medical Service, its Committee on Community Health Care, and more recently the AMA Interspecialty Committee, have been exploring methods by which to enhance the educational and evaluation components of peer review programs both in and out of the hospital, and I think this activity is most commendable and needed.

One additional mechanism for medical care evaluation deserves special mention; the self-assessment tests being developed or used by several of the major medical specialty societies. Interest in this type of test was demonstrated in 1968 when, under auspices of the American College of Physicians, well over 30% of the internists in the United States participated in a test consisting of 700 questions drawn from nine categories of special knowledge in internal medicine. At least ten other medical specialty societies are using or considering the use of such self-assessment tests. This form of self-evaluation enables the physician to pinpoint his own educational needs and indicates to the specialty societies which areas of knowledge require emphasis in planning the society-sponsored continuing education programs, which have shown a substantial increase in recent years.

My second major concern today is that of mechanisms or incentives to ensure that physicians participate in the currently available methods for maintaining competence. Incentives currently being utilized or considered by medicine and others can be grouped under three general categories; those involving the granting of awards or similar recognition, those which entail discontinuance of professional privileges and/or certification, and those which entail discontinuance of licensure or imposition of other legal sanctions.

On the national level, the American Medical Association's voluntary Physician's Recognition Award program is now two years old. This program, created by the AMA House of Delegates in 1968, offers special recognition to physicians who participate in a minimum of 150 hours of continuing medical education over a three-year period. To gain "Required" credits for the Recognition Award, the physician need not at present attend only continuing education programs accredited by the Council on Medical Education. However, it is expected that when all known institutions or organizations offering continuing medical education have had a chance to be surveyed for accreditation, credit for course attendance will be only for participation in an accredited course.

At the constituent level of organized medicine, the Oregon Medical Association has approved a plan to require periodic documentation by society members of participation in continuing education of a type and amount deemed appropriate by the association and by the specialty organizations representing the respective areas of specialty and general practice, as a condition for continued medical association membership.

In a similar vein, a workshop report from the Second California Medical Association Planning and Goals Conference in Medical Education recommended that "each physician seeking active membership" in the association "furnish evidence of having maintained his professional competence by participation in adequate approved continuing medical educational activities during the previous 12 months." The California Medical Association adopted a resolution in 1969 directing the CMA to "collect, codify and certify (physician) participation in accredited postgraduate education", and such a program was begun in August, 1970. Another workshop recommendation at the "Planning and Goals" Conference called for CMA to "encourage and sponsor 'educational testing of physician performance' on a pilot basis, following their involvement in programs of continuing medical education, in order to determine if they are utilizing and applying this knowledge in the actual care of their patients".

Participation in continuing education is also encouraged through hospital medical staffs in California. Over 100 hospitals in the state currently require each staff physician to report on a yearly basis his continuing education experience, as a prerequisite for staff reappointment. The Tennessee Medical Association indicated interest in stimulating members to participate in programs of continuing education by adopting a resolution in April of 1969, instructing its Committee on Continuing Education to "seek the cooperation of the Regional Medical Program to assist them in the promotion of the continuing education programs".

The Council of the Medical Society of Virginia, after considering a resolution endorsing the principle of assuring a minimum number of hours of postgraduate education as a prerequisite for renewal of license, adopted a substitute resolution recommending that consideration be given "to the formulation of a plan of continuing education for its members as a highly desirable credential for membership...". In like manner, the Pennsylvania Medical Society approved in principle a membership requirement of 150 hours of continuing education every three years and also authorized a study of relicensure as an additional incentive. Other medical associations are similarly involved in exploring incentives toward continued competence for their membership.

Another potential incentive toward continued physician competence would be a requirement for periodic recertification of the diplomates of medical specialty boards, such recertification to be granted on the basis of participation by the diplomate in continuing education of a type and amount deemed appropriate by the specialty board, or successful performance in an examination designed to test medical knowledge, diagnostic skills and the ability to prescribe appropriate therapy and analyze its results. The newly formed American Board of Family Practice now requires such recertification of its diplomates at six-year intervals, and the idea is being considered by other major specialty boards as well. A related incentive would be that of membership in the corresponding specialty society. One such society, the American Academy of General Practice, requires at least 150 hours of approved continuing education every three years as a condition for continued academy membership.

As I mentioned previously, increased attention is currently being given to the incentive of periodic relicensure, such relicensure to be granted upon documentation of participation in continuing education programs or, in lieu thereof, successful performance on a challenge examination in the practitioner's specialty. A survey conducted by the Arizona Board of Medical Examiners in May of 1969 indicated that 14 of the 38 other state boards responding were currently discussing the possibilities of periodic re-examinations for continuing licensure to practice medicine and surgery. Acting on a resolution at its 1969 Annual Meeting, the Arizona Medical Association has appointed an Ad Hoc Study Committee to work with the Board of Medical Examiners to determine mechanics of possible periodic relicensure and to study the possibility of requiring a certain number of postgraduate education hours for continued membership. The membership requirement possibility is receiving the major attention of the Ad Hoc Committee.

In California, A.B. 943 was introduced in the State Legislature and received a "do pass" recommendation from the Health and Welfare Committee in March, 1970. One portion of this Bill would add to the Medical Practice Act a section that would authorize the Board of Medical Examiners to require each physician at four-year intervals to prove that he had engaged in postgraduate studies, or in lieu thereof, permit the Board to require that "the holder of the certificate take a challenge examination once every four years". Following hearings, the State Legislature agreed to withhold enforcement of this portion of the Bill for three years, to enable the California Medical Association to implement its continuing education program. The Bill is now in interim study.

As another example of the use of legal sanctions in attempting to ensure competence, the State of New York, in implementing Title 19 of Public Law 89-97, established criteria of eligibility for physician participation in the program which in large part involves competence to practice and continuing education requirements. State regulation requires 150 hours of continuing education every three years for all physicians receiving fees under the program unless they are a member of the American Academy of General Practice, a member of a specialty society, or an active staff member of a JCAH-approved hospital. This provision has not yet been enforced.

I think that each of the incentives toward maintaining competence that I have described has merits and drawbacks.

For example, the Physician's Recognition Award program, because of its positive rather than punitive orientation and its sponsorship by organized medicine, is likely to be well received by most physicians. It assumes - and rightly so in my opinion - that the great majority of practicing physicians are already motivated to continue learning throughout their professional life, and provides special recognition for such effort. The program is, of course, completely voluntary, and thus cannot guarantee 100% involvement of practicing physicians.

Hospital staff membership can be both an incentive toward continuing education and a valuable mechanism in itself for such education. A certain minority of physicians, however, practice entirely without hospital affiliation. Another segment have staff privileges only at hospitals not accredited by the Joint Commission on Accreditation of Hospitals - an estimated 20% of all hospital beds.

The retention of specialty board certification, medical society or specialty society membership can each serve as potent incentives toward continued competence for a significant proportion of practitioners, but again, none of these alone applies to all physicians in practice.

The retention of medical licensure is an incentive which would apply to all physicians practicing medicine. In addition, despite some expressed opinion to the contrary, legal authorities generally agree that it is a valid exercise of a state's police powers to add to its medical practice act any additional conditions for retention of licensure that are deemed reasonable and proper in the interests of public health and safety. Periodic documentation of continuing education experience or passing of a challenge examination could be considered such a reasonable requirement. The drawbacks to this approach are primarily of a practical rather than legal nature.

To begin with, there is relatively little agreement on the degree to which participation in continuing education today is conducive to improved clinical ability, nor on the degree to which performance on any examination truly measures such ability. In order to incorporate these requirements into a body of law governing an individual's right to earn a livelihood by practicing a profession in which he is lawfully engaged, the standards for such participation or such performance would have to be set at a minimal leval, lest they be continually subject to successful contest or appeal by practitioners adversely affected. The result would be little if any improvement in the present ability of state medical boards to ensure physician competence. Further, very few highly competent specialists, after a few years of practice, could be expected to pass a relicensure examination given by a state medical board, an examination which of necessity would have to cover virtually the entire field of medical practice.

By contrast, when requirements for continuing education or reexamination are established by the profession itself, as conditions for specialty board certification, hospital affiliation or medical society membership, they can be set at more stringent levels since the basic ability of the practitioner to earn a livelihood is not so strongly affected, and can be continuously refined and tailored to individual fields of practice without the necessity of statutory amendment or changes in regulations.

On other factor should be considered in evaluating the worth of periodic relicensure as an incentive toward competence. In the face of admitted physician shortage, medical careers are already being made less attractive by high malpractice premium costs, escalating costs of medical education, increased governmental influence on the economics of practice and other factors. The creation of a limited tenure for a physician's license could well tend to make a career in medicine less attractive, and to accentuate the shortage of services. In view of the fact that periodic relicensure would have only a minimal impact on improving the quality of physician surveillance, I - and our Council on Health Manpower - are convinced that the drawbacks of this approach far outweigh the benefits at this time.

I believe, instead, that a pluralistic approach incorporating the other, intraprofessional incentives discussed previously offers the greatest potential for ensuring continued physician competence.

Specifically, I think we should encourage the recognized medical specialty boards to consider with their diplomates the desirability of establishing a periodic recertification program, such recertification to be granted on the basis of participation by the diplomate in continuing education, involvement in self-assessment programs, or other conditions deemed appropriate.

I think we should similarly encourage the recognized medical specialty societies to explore the desirability of establishing similar requirements for continued society membership.

I believe we should encourage increased attention by medical societies in cooperation and concert with medical specialty organizations and other appropriate groups to the development of self-assessment evaluation programs for physicians.

I think we should support the investigation by constituent medical associations of the desirability of requiring periodic documentation by their members of participation in continuing education as a condition for continued medical society membership.

I think we should strongly support the efforts of the Joint Commission on Accreditation of Hospitals to improve the education and medical care evaluation activities of hospital medical staffs.

I believe we should explore the possibility of developing some suitable mechanism by which medical staffs of unaccredited hospitals could be encouraged to continue their professional education.

And finally, I think that existing AMA policy relating to expansion of medical society peer review committees should be supported and implemented vigorously, and that particular emphasis should be directed toward expanding the educational aspects of such committees' functions.

The Council on Health Manpower in concert with the Council on Medical Education is developing a report on this subject of incentives toward continued competence of physicians. This report will incorporate a number of the suggested incentives I just discussed and will hopefully be submitted to the House of Delegates next month. If adopted, I believe the report will serve to reaffirm medicine's continuing dedication to ensuring the best possible care for every patient.

MOTIVATION FOR CONTINUING MEDICAL EDUCATION

C. JOHN TUPPER, M.D.

In the two years that have elapsed since the First National Conference of State Medical Association Representatives on Continuing Medical Education, a great deal has transpired in this area.

We daily hear increasing talk about postgraduate medicine and continuing medical education, about motivation, about peer review and control, about methods of determining needs, about timesavers, about self-assessment, and about issues and answers. And always about motivation.

It seems to me that the primary motivation for continuing medical education is, and must be, improvement in patient care. We engage in it all the time and we are most immediately and directly so engaged perhaps when we seek a hallway consultation with a colleague about a problem patient that we have just seen or when, in this same problem-solving orientation, to use the vernacular, we turn to the texts and journals in our offices to try to find the answer to a patient problem that is perplexing us. In other words, continuing medical education is something that every practitioner engages in every day. It is really true intellectual curiosity.

In his Presidential Address given in April of 1970 at the Annual Scientific Session of the American College of Physicians, and published in the August 1970 issue of the Annals of Internal Medicine, Doctor Samuel P. Asper said as follows when he addressed the new Fellows of the College: "Whether or not you accept the popular, recently expounded Peter Principle as a valid expression of our modern way of life, I wish to reassure the newly inducted Fellows that you have not reached your present status by demonstrating competence to a degree which henceforth represents your level of incompetence. My belief is that the Peter Principle does not, or at least should not, apply to our profession in these days in which we stress continuing education. One never graduates in medicine; one never achieves a level. On the contrary, one is always on the incline in both knowledge and proficiency. So, continuing education is our lifeline, and whatever may come in the reorganization of our way of doing business in coming years, we must not overlook this factor.

"Curiously, however, we do not know best how to fulfill this need in the graduate phase of life. What is the best method of continuing education? Some feel it resides in annual scientific meetings like this. Others say we need daily, or at least weekly, instruction through rounds, conferences, and seminars. Still others find the medical knowledge self-assessment test helpful. We must not overlook, however, two fundamental aspects of continuing education. The first of these is to accept our patients, especially those with illness we do not understand, as a direct challenge to increase our knowledge for their sake. The patient benefits most, and knowledge gained in this way has a protracted half life of retention as compared to that gained in any other way."

There are many other motivations for continuing medical education, of course. These include enhanced respect of colleagues, personal reassurance, the combination of continuing education activity and travel with some tax advantages, professional prestige, and others.

And now, today, two new motivators have come upon the scene, called certification and accreditation. The necessity for a new role for continuing education in medicine and the other health sciences has been increasingly recognized by organized medicine. The American Medical Association and the State Societies have focused attention on this by way of studies, surveys, and through discussion. Of equal importance is work performed by community hospitals, specialty groups, and even county medical societies.

Some measures already taken include approved or recommended policy with regard to continuing membership in medical societies based upon participation in continuing education programs. Regulations have been adopted in some places with regard to requirements for hospital staff membership and, of course, there are more than a few legislative proposals in which relicensure or recertification of the physician would be based upon the use of participation in continuing medical education efforts as evidence of the continuing competence of the physician. It seems quite apparent that a trend has been established that is leading us inexorably toward some degree of mandatory attendance or participation in various forms of continuing education activity.

In our discussions of motivation, we must consider not only the maturation of the student, but also the motivation of the purveyor. And we must keep evaluation, motivation, and continued study of the process in mind. As brief examples of the importance of this, I refer to a recent report from the Division of Socio-Economics and Research of the California Medical Association which considered physician opinions about continuing medical education programs. In a survey of some 4,500 physicians, almost half answered that they attended continuing education programs occasionally, just under one-third indicated that they attend often while the remainder, amounting to more than one-fifth of all physicians said that they rarely or never attend such programs. With reference to age groups, respondents aged 38 and under attend relatively frequently; those in the next age group (39 to 48) less frequently; those in the next group (49 to 58) more frequently; and those in the oldest group (59 to 69) with increasingly less frequency. Respondents were asked to provide ratings of effectiveness where nine modalities were employed in the area of continuing medical education.

It was of interest to find three to six months traineeships in teaching institutions rating highest of all modalities in effectiveness, with 86.6% of respondents acquainted with the modality, rating it very effective. Two other modalities followed closely in the ratings - two-to-three day symposia, and one-to-three week in-service programs at 76.1% and 75% respectively. Textbooks and journals, while universally familiar to physicians, are rated lower on the effectiveness scale, but two out of three respondents still consider reading a very effective means of education. Bedside postgraduate courses in medical schools ranked just below reading materials with 62.75% rating them very effective. Hospital radio conferences ranked lowest in terms of effectiveness with one clinician in five considering them relatively ineffective and over half calling them only somewhat effective, and medical television ranked next lowest. This merely emphasizes the importance of our not becoming confused between gadgets and content and of our making every effort to maintain objectivity in analysis.

In my judgment, medical schools can no longer afford the luxury of considering their responsibility completed with the awarding of the M.D. degree. Well over 80% of medical graduates in the United States go on to advanced training beyond the internship. Participation in this part of medical education, as well as in the continuing education of the practicing physician, is an ever more clear responsibility of medical education. It is a responsibility that begins with enrollment in medical school and does not end until the physician dies or retires. It incorporates the responsibility for the medical school to initiate the habit of continuing education and to stimulate and encourage the motivation for it career long. At the same time, there must be a clear recognition of the fact that this is a problem that cannot be met by the medical schools alone. The tremendous reservoir of talents, ability, and motivation that exist in the practicing community must participate in continuing medical education programs and efforts.

The medical schools may serve as an organizing and a synthesizing force to help to harness, tap and coordinate all of this talent and, indeed, we see this happening through efforts in continuing medical education on the part of the schools of medicine, through the developing regional medical programs, and through the elements of organized medicine, with state medical societies and associations frequently taking the lead, along with the specialty societies.

In a general way, I should like to make several points about responsibilities in motivation for continuing education.

First, and to repeat, the medical school should initiate the "habit" of continuing education. It should bring back the physician and involve him with students. It should establish an academic department of continuing medical education and programs and it should assure participation by faculty of all levels.

Second, the purveyor of continuing medical education must make the programs attractive. This means good faculty. It means that the material presented must be new and relevant, including some that may not be necessarily useful at the moment. It must be available at the convenience of the practitioner, with this meaning weekly and daily presentations, as well as two-and three-day programs, and it must be characterized by variety, for no one type of effort will please all.

Third, we must use continuing education programs as a two-way communication between faculty and practitioners.

Fourth, we must study and ascertain the best time of the week for the two- to three-day type of programs, and,

Fifth, we must recognize certification requirements in national organizations, state organizations, state government, hospital staff requirements, and others.

Sixth, we must continually recognize that the real thing is better patient care, using the newest and best and that this is possible only through some form of continuing education.

Seventh, we must do a good public relations job of continuing contact with those responsible for continuing medical education with physicians, making sure that they are taking into account their convenience and their interests as well.

Sir Eric Ashby predicted, "The University of tomorrow will constantly be bringing graduates back for retraining - indeed... we may come to regard a university degree as we do a passport; it will expire every ten years unless renewed." I do not think we are at that point yet. However, legislation has been introduced in several states with regard to measures to assure the continuing competence of the physician. As we move toward methods for gaining this assurance through participation in continuing medical education, accreditation will become a necessity, if only in order to ascertain what efforts by the individual physician will count toward his recertification. In my judgment, for relicensure or renewal of license to be carried out by examination through agencies of the government would be wasteful and ineffective. Rather, I believe that we must demonstrate to those responsible agencies that there is a successful and an effective voluntary way for assuring the continuing competence of the physician through efforts on his own behalf to continually upgrade and update his fund of knowledge, his skills, and the manner in which he uses them. There is a strong source of motivation and this is a strong argument for new support, new interests, and new involvement in continuing medical education.

In all of this, the medical school must play a role, but it cannot do it alone. We cannot see continuing education as something retained within the ivy covered walls. Indeed those walls must come down and we must become schools of medicine and universities without walls and move into the community as cooperative and responsible members of the medical profession itself with our own effective motivation for continuing medical education.

PEER REVIEW AND EVALUATION AS EDUCATIONAL TOOLS

ROBERT L. EVANS, M.D.

ABSTRACT

Evaluation of the quality of medical care and education in hospitals are inseparable. The basic requirements for education at the undergraduate, graduate and continuing levels in the hospital setting are presented. Recent legal changes in the professional and educational roles of the hospital are discussed in relation to their effect on medical staff organization and operation. The discussion is primarily directed to medical staffs but also involves the roles of hospital boards and administration in education and evaluation of the quality of care.

INTRODUCTION

The legendary independence of the physician, the transmutation of many professional societies into political and social groups, the emergence of intensive subspecialization and its accompanying colleges, have all conspired to diminish continuing education as a mandate of the professional peer group.

These factors have diluted responsibility for continuing education and produced a potpourri of educational efforts and a smorgasbord of offerings. There are so many methods, places and types of education available to the physician that it is impossible to determine whether he practices abstinence, normophagia or gluttony at this educational banquet. Educators working with practicing physicians are acutely aware of how the pressures in our undermanned medical care delivery system make ineffective the formal courses offered at medical centers, the sophisticated TV and radio programs and the plethora of printed pages made available for continuing education of physicians.

THE HOSPITAL

Recent changes in the hospital's role have begun to counteract this confusion of place and purpose and to emphasize physician education as a local activity.

The new forces are: (1) the legal redefinition of the role of the hospital, its governing board, medical staff and administration and (2) the functional redefinition of the hospital as an educational institution within the community.

Although legal redefinition has direct bearing on the continuum of care and education and will be discussed briefly, redefinition of the educational role of the hospital will be the main subject of this paper.

LEGAL REDEFINITION

In our society, definition of responsibility through the courts usually precedes definition by legislation. Recently there have been two major decisions involving the assurance of quality of care and continuing education in hospitals.

The first, the "Darling" suit in Illinois[1], has already produced change in attitude and responsibility. Briefly, it states that the entire hospital community (the governing board, the medical staff and the administration) is responsible for assuring the quality of care within the institution. The implication of this redefinition of responsibility to the professional peer group is obvious. Its effect is already evident in the new hospital regulations in the state of Michigan[2] and in the awakening interest of hospital boards and administrations all across the nation in assuring quality of care.

The second decision grew out of a recent suit in New Bedford, Massachusetts.[3] An anesthesiologist administered a spinal anesthetic based upon information contained in the package insert. The patient had residual neurologic loss. A lower court acquitted the anesthesiologist, despite expert testimony to the effect that the dose was excessive, on grounds that the procedure was consistent with local practice. The decision was reversed by the Supreme Judicial Court of Massachusetts on the ground that modern communication is so efficient and continuing education so readily available, that any specialty physician must function on a national level of competence, and that balkanization of ability in medicine must cease.

The impact of this decision is that any physician, anyplace, must be able to practice at a national level of competence. His failure to do so (and the hospital's failure to assure that he does) can be interpreted as criminal neglect. This invalidates one of the major defense positions assumed in malpractice suits for the past 100 years.

Both decisions make mandatory the involvement of hospital staff, trustees, and administration in the evaluation of patient care and in continuing education.

REDEFINITION OF THE HOSPITAL'S EDUCATIONAL ROLE

Professional, social, and governmental pressures are making the hospital a comprehensive medical care center. Because such care requires sophisticated professional and technical personnel, the hospital must also become a health education center for the area it serves.

Hospitals can be the focal point where the patient, the physician, and the mechanism for analyzing their interaction can be brought together. No better place exists to educate the physician than the institution in which he cares for his patients, meets his peers, and earns his living.

THE RELATIONSHIP OF PATIENT CARE AND EDUCATION IN THE HOSPITAL

It is no longer possible to limit interns and residents to the level of excellence of a single preceptor. Graduate students must be afforded the opportunity to work with many different physicians, to see many different techniques, and thus to become more competent than any individual preceptor. This goal can be attained only when the physician staff of the hospital is active in its own education as well as its students. One cannot teach what one does not do himself. Graduate students are great mimics, as are physician peer groups. What the group does is determined by the performance of its leadership. Attitudes and performance are determined by contact with those whom the learner seeks to emulate.

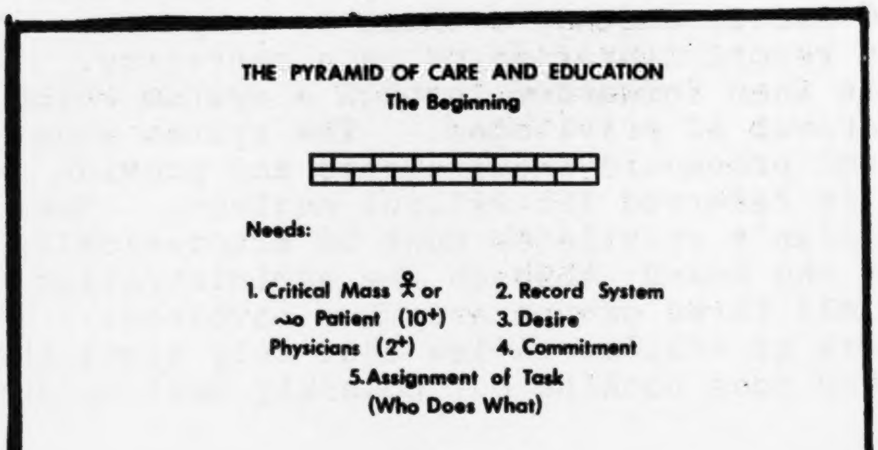
As a profession, we have traditionally separated the evaluation of patient care from the educational functions of the hospital. The theme of this presentation is that the evaluation of patient care and education in our institutions are not just similar, or interrelated, or interwoven - they are the same. There are three relationships which weld quality of care and education together.

First, quality of care analysis provides the information on what the members of a staff know and do not know. It examines the fabric of patient care and, more important, the gaps between the fibers of that cloth.

Second, evaluation of patient care produces involvement by providing the physician with the pertinence missing from television, radio and journals. It provides him with a basic textbook (the patient) that is valid within the physician's own setting, using the skills, equipment, and support available to him in his daily work.

Third, every one of the traditional continuing, graduate and undergraduate educational exercises is also an exercise in evaluating quality of care.

There is an additional gain to the physician in using his hospital as an educational base. He can learn during time already set aside for his professional functions. Television networks, two-way radio exchanges and other programs based on electronic media have received wide publicity. These programs have a place, but that place is severely limited. The physician has a major problem. There are a large number of patients waiting for his care. He has not sought them and he rarely worries about his income from them. There are not enough hours in the day for him to provide needed care. He jealously guards time set aside for his family, his personal commitments and his avocations - time required for his own emotional and physical health. He is not going to cut into this time for any purpose. Programs for continuing education that are scheduled in nonprofessional time are destined to fail. But, education scheduled in the hospital occurs during the physician's professional hours, and he will accept it as part of his normal work pattern.



THE PYRAMID OF CARE AND EDUCATION

The Beginning

Needs:

1. Critical Mass or
Patient (10^+)
Physicians (2^+)

2. Record System
3. Desire
4. Commitment

5. Assignment of Task
(Who Does What)

Figure 1.

Competent hospital education and quality of care programs can become a solid foundation upon which can be built a pyramid of graduate and undergraduate education and research. The concept of the pyramid combines all activities into a continuum of concern, care, education, and continued concern - a regenerative and self-sustaining reaction. Figure 1 shows the solid foundation of the pyramid.

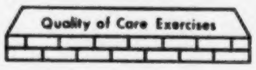
There is a critical mass of patients (textbooks) who form a "library". The patients should be both vertical and horizontal (out and in-patients). Ten is enough. Another requirement is at least two physicians who can interact. The institution concerned may be a hospital, a group practice, a clinic or any other medical institution which brings together physicians and patients. The minimal needs are small indeed.

The second need is a record system which catalogs the "library" by accurately recording the care that physicians are rendering. Most records monotonously note that the patient is "doing well today". A useful record is one that clearly states the patient's problem, shows the thought process the physician used to get at the problem, and records the results. Thus both process and product may be analyzed. Dr. Lawrence Weed[4,5] proposes a record that systematizes the information obtained. Such records present the patient's care in a manner that is easily understood and evaluated. Content, while important, is only one part of a record system. Organization of the content and presentation of a logical plan of action are equally important.

Most hospitals fail to develop the staff discipline which insures prompt and complete records at discharge. It is difficult for a record committee member to meet with a colleague and recommend removal of his hospital privileges because his charts are incomplete - and then play golf with him on Saturday. A committee of physicians is not needed to decide whether a chart is complete. This decision can be made by a record librarian or by a secretary. Information on delinquency is then forwarded through a system which automatically results in withdrawal of privileges. The system should carefully delineate time and procedure requirements and provide safeguards so that discipline is reserved for willful neglect. When such neglect appears, a physician's privileges must be automatically revoked by the authority of the board, through the administration, at the request of the staff. All three groups are then involved. There should be appeal, but beware of endless review that only slows the completion of the records and does nothing but possibly destroy good golf foursomes.

Numbers 3, 4 and 5 (Figure 1) are three remaining needs that are common in decision making. Desire, commitment, and involvement produce "motivation". "Motivation" is the rock upon which the splintered ship of continuing education often founders. Motivation will result whenever relevant, locally valid material is offered in a manner which does not disrupt the physician's primary burden - delivery of care. One cannot simply "motivate" as an end in itself. To motivate the physician one must relate his continuing education to his daily effort, for both are part of a continuum.

THE PYRAMID OF CARE AND EDUCATION
The Heart of Continuing Education



Needs:	Methods:	Exercises:
1. Critical Mass	1. Consistency of Leadership	1. Department Meetings
2. Record System	2. Attendance Requirements	2. Audits and Consec. Case. Conf.
3. Desire	3. Chart Discipline	3. Morbidity and Mortality
4. Commitment	4. Pertinence	4. Tissue Committee
5. Assignment of Task		5. Executive Committee

Figure 2.

Figure 2 lists the basics of Figure 1, the methods of meeting these basic needs, and some familiar friends.

CONSISTENCY OF LEADERSHIP

Members of hospital staffs are only dimly aware of the importance of consistent leadership. Many are so busy maintaining personal freedom and "democracy" that they do not realize they are producing educational and professional anarchy. The major problems of our hospital staff system today is that it is just too democratic. In many hospitals, every officer of the staff, every committee chairman, and every Department chairman changes every year. Medical staffs should be republics - not organizations that carry "freedom" to the point of irresponsibility.

Department chairmen should have tenure long enough to allow their basic philosophies and abilities to be effective. How can a man have pride in his accomplishments when they may be neglected in a year or less? The staff by-laws of most hospitals sorely need review. Tenure appointment through a board and staff cooperation rather than election should select the best and most qualified leaders. A minimum service of 4-5 years for department chairman and executive committee members allows time for growth and an opportunity to exert knowledgeable leadership. This should not preclude a mechanism for removal, but it does preclude replacement on a schedule that is little longer than the gestation period of Man - and far too short for any man's ideas and abilities to produce change.

ATTENDANCE REQUIREMENTS

Voluntary assumption of an additional commitment is difficult, but most physicians still have an altruistic "need to know". This need will create many attendees, especially if the time chosen is convenient and the program of high quality. Still, many physicians will not attend. If exercises are worth attending, reasonable attendance requirements must be initiated and supported by peer pressure and group responsibility. Thus a critical mass of learners may be assured.

Attendance requirements can become as automatic as in the system of record discipline noted previously. As with record discipline the system can be fair, impersonal, and so automatic as to insure enforcement only when an individual is irresponsible. A staff secretary can decide whether a physician was present at a meeting. Requirements must be reasonable, clearly stated, and only illness or absence from the community acceptable excuses. The new J.C.A.H. regulation of at least 50% attendance is minimal, though barely sufficient for a department conducting an educational program for house staff officers, for such departments having responsibility for teaching as well as learning.

THE EXERCISES OF QUALITY OF CARE

To the right (Figure 2) is a group of familiar activities. The list contains educational exercises that are familiar to all physicians. A common thread runs through all of them: CPC's, audits, consecutive case conferences, morbidity and tissue committee sessions.

Departmental meetings should be based upon what that department's members are doing with their patients, not an intellectual discussion of rare disease. Department meetings can be subject oriented by drawing up a list of 60 or 70 subjects for a 52 week year and then utilizing patients, as they become available, to illustrate the subjects one at a time. Pertinence will be maintained, because the patients are cared for by the physicians of the staff with the tools and skills present in the institution. Grand rounds can function in similar fashion. Passive attendance at didactic lectures generally dulls any sense of involvement and fails to add to a lasting store of information.

Teaching exercises based on identified needs should obviously be the most productive. Audits are designed to identify educational needs through examining what is being done (or not done) and comparing it to local or national criteria.[6] Such audits may be either individual chart review or group review against minimal criteria. Both types are needed. Data-processed information enables a systematic approach through supplying grouped data.

The role of PAS-MAP*, HUP**, local computers, conglomerate computer banks, and other purchased services is to provide categorized information. Such information cannot be "read" like a book. It must be approached with performed questions of a specific nature. If not utilized in this manner, computer systems create a false sense of security by promoting the feeling that data acquisition replaces the detailed review of individual patient care. But the basic requirement is for complete and systematic patient records. With such records, both computerized and individual review can become educationally significant.

Morbidity and mortality conferences and tissue committees must not be disciplinary exercises. Open discussion, with no attempt at identification of the individual physician or patient involved, allows identification of defects in methodology rather than finding of personal fault.

The executive committee is listed under these exercises because it must be the group with more influence on education than any single hospital committee. The executive committee must initiate and maintain the staff commitment. This committee is the talisman of peer pressure. Unless it is a working committee which truly represents the staff, educational exercises become, at best, the personal tour de force of a department chairman, and at worst, a travesty of education which provides an excuse for continuing ineptitude and lack of involvement.

---

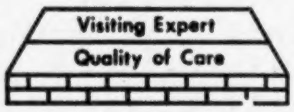
* The Professional Activities Study and Medical Audit Program of the Commission on Professional and Hospital Activities, Ann Arbor, Michigan.

**The Hospital Utilization Program, Pittsburgh, Pennsylvania.

In some institutions the staff may be so large or complex as to require paid Director(s) of Continuing Education. The function of such individuals is to provide educational organization and backup to a voluntary staff. They must support and not substitute for the voluntary effort of the staff.

The familiar care and education exercises, long considered essential for house staff teaching, are the guts of continuing education for a medical staff. That it is necessary to add little to make such education totally effective as is seen in Figure 3.

THE PYRAMID OF CARE AND EDUCATION
Complete Continuing Education



Visiting Expert Adds:	**Exercises:**
1. New Concepts	1. Those For Quality Of Care
2. Different Methods	2. Rounds
3. Continuing Education	3. Talks
	4. Conferences

Figure 3.

THE VISITING EXPERT

The visiting expert may be from across town or across the world. Only two factors are of importance. First, he must be from without; and second, he must have expertise and interest in his subject and in teaching. His contribution is small, but critical. His fresh approach combats the inbreeding which can sap the life of any institution.

The visiting expert must not just lecture. He must be involved in as many educational exercises as possible. He should join consecutive case conferences, audits, rounds, seminars, and conferences. Some activities may be specifically designed for him, but he will be much more effective if he joins in the staff's regular activities. Seemingly insoluble problems become soluble under the light of a fresh, unbiased look.

By completing review of basic needs, methods, quality of care exercises and the visiting expert, we have reached the first plateau of the Pyramid of Care and Education, the Plateau of Continuing Education.

THE CONTINUING EDUCATION PLATEAU

No matter its size, or type, the institution which has reached this level of function has assured the people it serves that it has (1) concern for the quality of care being rendered within the institution and (2) concern to design relevant continuing education that will intellectually rejuvenate the staff. In most of our nation's over 7,700 hospitals this pyramid need grow no further, for it already insures quality health care. These hospitals need conduct only reparative and continuing staff education to assure the consumer that he is receiving a quality product. It would be difficult to produce genuine institutional, staff, and individual competence in any other way. The hospital functioning at this plateau is a totally competent educational institution, with the intellectual stimulus to produce a regenerative cycle of physician motivation.

The medical staff that does not embody these concepts in daily operation has no moral or ethical right to exist. Their hospital will become a nursing care facility, for separation of proper utilization of hospital facilities from education and its continuing pursuit of excellence is umbilical contemplation that is both depressive and destructive. To accomplish such separation will bring down upon us the righteous wrath of those we serve and destroy all that is presently good in our voluntary system.

A hospital that has reached competence in continuing education may wish to conduct programs of intern and resident education. The simplicity of the pyramidal concept is that most of the work which will be necessary to establish competent graduate education has already been accomplished.

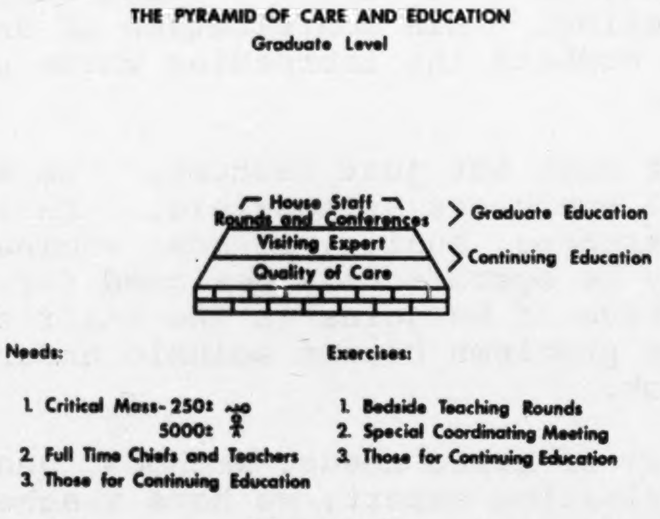

THE PYRAMID OF CARE AND EDUCATION
Graduate Level
House Staff
Rounds and Conferences
Visiting Expert
Quality of Care
Graduate Education
Continuing Education
Needs:
1. Critical Mass- 250±
5000±
2. Full Time Chiefs and Teachers
3. Those for Continuing Education
Exercises:
1. Bedside Teaching Rounds
2. Special Coordinating Meeting
3. Those for Continuing Education

Figure 4.

THE NEEDS FOR GRADUATE EDUCATION

There are two additional requirements for the institution which will conduct graduate programs. These are: (1) an increase in the critical mass of patients and doctors and (2) the addition of full-time educational personnel.

One or two graduate students cannot function alone - most review committees agree there should be at least six or eight. Thus a critical mass of 250± horizontal patients and 5,000± vertical patients is necessary to create the critical information and experience mass for this minimum number of graduate students. In specialized hospitals the patient mass may be smaller since the graduate program is more narrowly defined. The figures given are for a general hospital engaged in internship and major clinical residency programs.

The increasing sophistication and complexity of the day-to-day planning, operating, and evaluating of graduate education programs demand ability and time not available to most staffs. Someone must be paid. He may be a full-time or part-time department chairman or a program director whose major purpose is to supply organizational and teaching skills. He will be successful only if he supports and leads the voluntary staff but does not supplant the voluntary teaching effort.

The unique offering of the community hospital in graduate education is the opportunity for constant contact between the graduate student and practicing physician. The cry of the undergraduate and graduate student in medicine today is for relevance of his education to his future effort in the care of people. The students often find fault in the university educator's lack of involvement in patient care. Involvement with practicing educators is the prime offering of the community teaching staff. Acceptance of this product by the university and its student will depend on the quality of the performance of the staff, not on the full-time teachers or equipment in the hospital.

The paid teacher in the community teaching hospital must provide backup to the voluntary staff that allows the practicing physicians to spend their time in actual teaching and not in scheduling, planning and other non-student related activities. The community teaching hospital which attempts to emulate the total full-time staff of the university is predestined to be a less than adequate copy. It does not and will not have the financial or intellectual resources to provide the depth that seems natural to the layered specialization of the university atmosphere. It may even destroy its voluntary teachers by competitive inhibition. However, judicious use of paid teachers and leaders in the community teaching hospital may allow it to assume excellence in an area which is now beyond the grasp of many university hospitals - the triangular involvement of the graduate student, the patient and the practicing physician.

THE EXERCISES FOR GRADUATE EDUCATION

If one reviews Figures 2 and 3, one finds that virtually every exercise necessary for graduate education is already being conducted within the institution. Only two things need be added for effective intern and resident education: (1) bedside teaching rounds and (2) a series of special meetings coordinated for the graduate level.

Daily bedside teaching rounds remain the primary exercise of graduate education. They are the most valuable legacy of the apprentice system of medical education and need no further mention.

Two types of conferences are needed for graduate education: (1) special programs designed around needs which may not have yet been met for the graduate student and that could run the gamut from the emergency room care of eye problems to the host of legal, moral and ethical considerations or practice not covered in medical college curricula; and (2) a coordinating and business conference that provides group identification and makes the graduate student a member of the practicing community. It is a forum conducted by the senior educational officer of the institution, and provides an opportunity for the intern or resident to state his problems and desires in education, creature comfort or philosphy. The intern and resident also learns the problems of the staff and institution in such interchanges. He may also benefit from appointment to hospital staff committees, as well as contributing a special knowledge to staff effort.

The pyramid has now reached a second plataeu, that of graduate education, built on a firm base of quality patient care and continuing education of an involved medical staff. Can there be a better assurance of effective education at the graduate level?

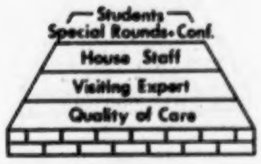
The institution which reaches the second platequ has solved most of its major problems in care and in the education of its own staff and is now able to give solid support to undergraduate medical education. It must not enter undergraduate education expecting the medical college to solve hospital service or staff problems but, hospitals that have solved these problems themselves become an invaluable resource for undergraduate education. Figure 5 illustrates this next step in the development of the pyramid.

THE UNDERGRADUATE PLATEAU

Figure 5 shows the introduction of medical students to the pyramid of care and education. The critical mass, the full-time educators, and the exercises for continuing education are already operative. What is needed in addition?

Teachers involved in undergraduate education must be paid. There are two reasons: (1) this level of teaching requires a rare individual who has a dedication and interest at a basic level - pathophysiology, pharmacopathology, cytochemistry, etc.; and (2) this type of educational involvement gives little return to the teacher in recognized terms of service to his patients.

THE PYRAMID OF CARE AND EDUCATION
Undergraduate Level



Needs:	Exercises:
1. Compensated Teachers	1. Special Bedside Teaching
2. Critical Mass	2. Special Correlative Conferences
3. Full Time Chiefs	3. Those for Graduate
4. Those for Continuing Education	4. Those for Continuing Education

Figure 5.

Not all physicians have the basic drive and interest for undergraduate teaching. Some are threatened by students. In continuing and graduate education such individuals can work productively in journal clubs, audits and in committee work. One may even consider physicians according to "Rumble's Rule" (Doctor Lester Rumble), which states that no staff physician is worthless - he can always serve as a horrible example. At the undergraduate level of teaching, payment allows the program planner to include or exclude physicians who may - or may not - be good teachers. The compensation may be taken, but its existence is a potent force.

EXERCISES FOR UNDERGRADUATE EDUCATION

In the hospital that has built the continuing and graduate education plateaus, the special exercises required for undergraduate teaching are minimal. They consist of a few special bedside teaching and correlative conferences.

Bedside teaching may be partially combined with that directed at the graduate student. Correlative conferences, twice or three times per week, are designed for a deeper search into basic mechanism. All the exercises already established for graduate and continuing education are available to the medical student. There is constant emphasis on the quality of care of patients to whom the student and his conferees at the graduate and practicing physician level are devoting their daily efforts. The foundation remains firm and relevant.

The pyramid is now ready for its capstone.

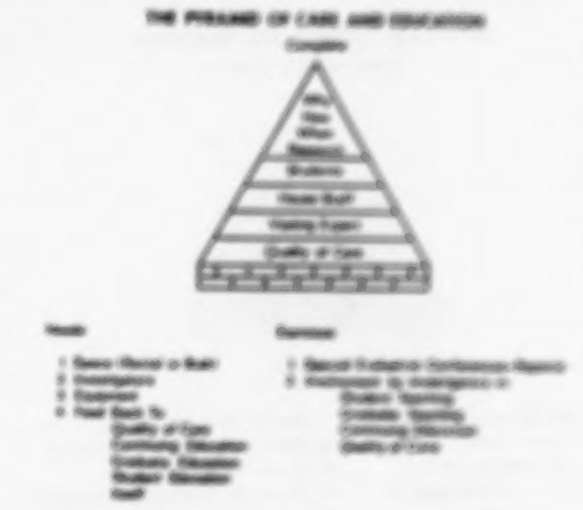


Figure 6.

THE RESEARCH CAPSTONE

Research activities may cap any of the three plateaus previously identified. Most hospitals will place the cap over the continuing educational level. The presence of this investigative cap will compliment any level of educational program.

If some of the staff might wish to do basic biomedical research, they should be encouraged, especially in the hospital conducting graduate and undergraduate programs. Such activity will provide an atmosphere of sophistication in the search for knowledge which is vital to the community teaching hospital. In smaller institutions, this orientation may be fostered by the visiting expert. Research personnel should be involved in student, graduate and continuing education through the medium of special evaluative conferences.

Research, in most hospitals, is asking why, how and when a patient care function is best done and how it may be done better. This is investigation into the delivery of medical care, a continuing search for excellence. The identification and solution of such problems is care-oriented research. It is completely applicable to our pyramid and provides basic information to fuel exercises at all levels of continuing, graduate and undergraduate education. Patient care research is the final link in the regenerative information cycle.

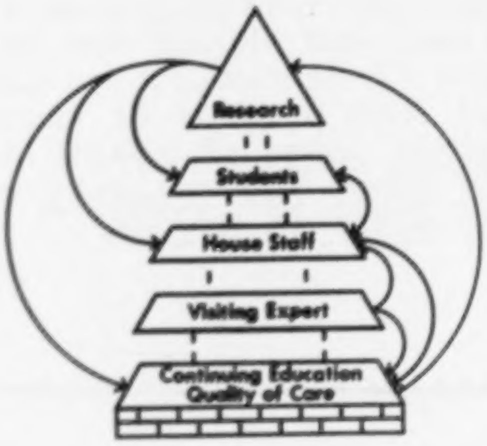


Figure 7.

THE REGENERATIVE FEEDBACK CYCLE

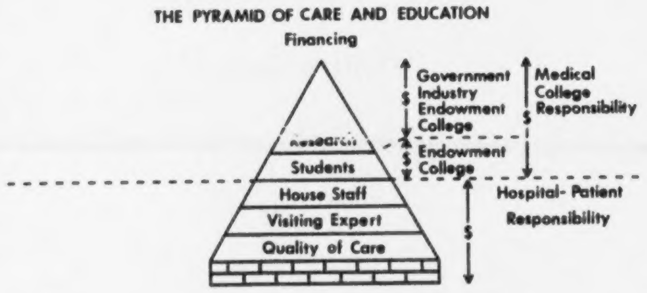
Figure 7 illustrates the feedback that occurs among all levels of the pyramid of care and education. Every level of the pyramid is based on what has been done at a lower level and is strengthened by feedback from the higher levels.

Finally, we come to the finance.

THE FINANCING OF CARE AND EDUCATION IN THE HOSPITAL SETTING

In Figure 8, every item below the dotted line is a legitimate cost of quality care. This cost will average between $1.50 and $4.00 a patient day, depending upon the level at which the program functions. What more cost-effective expenditure could the patient and his community make? In those hospitals with interns and residents there is the additional assurance of immediately available physician services. Finally, the interns and residents provide a pre-selected, pre-screened, community resource of competent physicians for its future care.

The same paid teachers who function in graduate and continuing education may function in student education, and teaching facilities have dual purposes - thus the same dollar buys services in two or more areas, but above the dotted line lies an area of fiscal responsibility which transcends the individual hospital. The medical student may settle anywhere when he graduates. Research knowledge (beyond that which is limited to review of the delivery of health care within the institution) is applicable on a national scale. In affiliate hospitals, direct student expenses clearly require financing by the medical college or university. Whether or not the hospital is a major affiliate, funding of basic research should still be from endowment, philanthropy, government or industry. Basic biomedical investigation is not directly related to the care of the patient and should not be added to his financial burden. But, the costs of investigation into the delivery of quality health care and into methods of increasing its efficiency and compassion are logical costs of health care. They are quality controls in an industry where the delivery of maximum health years for the populace is the ultimate product.



College:	Joint:	Hospital and Patient:
1. Space	1. Full Time Chief	1. House Staff
2. Investigators	2. Class Rooms	2. Visiting Expert
3. Equipment	3. Building Support	3. Full Time Graduate Teachers
4. Full Time Teachers for students		4. Medical Administrators
		5. Continuing Education
		6. Quality of Care

Figure 8.

In one city (York, Pennsylvania) an average of nine physicians from residencies in its community hospital enter practice every year. Graduate students have the opportunity to measure the community's specialty needs and to modify their own education plans accordingly. An additional number of physicians who have been educated elsewhere are attracted to practice in York because the hospital's program assures continuing opportunity for education and excellence in practice. In ten years the physician-patient ratio in the community has risen from 76 per hundred thousand to 110 per hundred thousand and now remains abreast of population growth. These figures testify to the value of this pyramid to the community as well as the hospital in which it functions.

SUMMARY

The administrators, boards of directors and medical staffs who are responsible for quality of health care must stop arguing about their roles. Society has already placed the responsibility on them all, and society will not fractionate the assignment. But, physicians, as the ultimate producers of health care, must accept the basic charge to a learned profession - to assure the ability and performance of its members. If not, the profession shall truly deserve the derisive accolade "trade union". The "buck stops" with the medical staff.

The community teaching hospital is a potential means for education of practicing physicians and for many graduate and undergraduate students. Community hospitals can provide the broad based, pertinent education for all except the most narrowly specialized physician groups. They can provide the basic education in medical care and delivery that is increasingly difficult in the medical college.

The structure of patient care and education is unitary. Quality of care and continuing education are not just inseparable. They are the same. The cost to the institution and community of education programs is infinitesimal compared to the monetary and human cost of attempting health care without them. Unless physicians accept the challenge and perform the tasks assuring their own competence, the epithet "trade union" will become their epitaph.

INDEXING TERMS

Continuing Education

Graduate Education

Undergraduate Education

Quality of Care Evaluation

Hospital

REFERENCES

1. *Darling vs. Charlestown Community Hospital 211 NE 2d 253.*

2. *John F. Horty, "Michigan Statute Tightens Trustee Control of Care" MODERN HOSPITAL, Vol 112, #1, p. 48-50, January, 1969.*

3. *Teresa Brune et al vs. Stanton Belinkoff 235 NE 2d 793.*

4. *Lawrence L. Weed, M.D., "Medical Records That Guide and Teach" NEW ENGLAND JOURNAL OF MEDICINE, Vol. 278, No. 11, p. 593-599, March 14, 1968.*

5. *Lawrence L. Weed, M.D., "Medical Records That Guide and Teach (Concluded)" NEW ENGLAND JOURNAL OF MEDICINE, Vo. 278, No. 12, March 21, 1968*

6. *Beverly C. Payne, M.D., Editor - HOSPITAL UTILIZATION AND REVIEW MANUAL, University of Michigan Press, February, 1968.*

REGIONALIZATION AND CONTINUING MEDICAL EDUCATION

E. GREY DIMOND, M.D.

Doctor Curry was seeing his last office patient for the day and though weary, was not "wrung out" as usual on Friday evening. He had had with him for the entire day young Cross, third-year Resident in the Comprehensive Health Care residency at the Medical Center. Young Cross had come down to Riverport to be in locum tenens for Doctor Curry, while Curry goes up to the Medical Center for his annual two-week sabbatical leave.

Doctor Curry briefed Cross thoroughly and was relieved as it became apparent that Cross was not only competent, but made friends readily with the office staff and patients. This was the fourth year since Curry had joined the Medical School continuing education program and his office staff was now completely relaxed about his annual visit up to Metro City and the Medical Center.

Cross' wife had come with him and this was the second locum tenens for them. The Comprehensive Health Care residency required two such experiences in the last year of training. All of the residents looked forward to these times. The locum tenens provided a real opportunity to look over a possible practice location, gave one a chance to considerably broaden his experience in the handling of health problems which just did not surface at the Medical Center. And not least was the addition to his salary during this two-week period. The plan of financing that had been worked out for the overall program had proved happy for all. Doctor Curry paid a once-a-month stipend to the postgraduate center at Metro City and although this sum was substantial, it made the two-week period seem painless. For his monthly stipend he received the postgraduate center's audio tape journal every two weeks. This brought him the best panels and discussions that had gone on in the Center. The locum tenens cost for Doctor Cross was paid from this same education account, and now Doctor Curry was leaving for his two weeks, comfortable with the knowledge that his education account would take care of all his living expenses and tuition while in Metro City.

Next year Doctor Curry would increase his monthly allotment as the closed-circuit cable television link from Metro City would be in operation. The cost of this would not be too great as Riverport's hospital had shared in the cost. The hospital had signed with the Medical Center as a satellite hospital and an agreement had been worked out for consulting backup in radiology and most of the specialties.

One of the real pleasures of his education fund was that it gave him permanent membership in and therefore, ready use of, the superb facilities of the Academy of Health Professions at Metro City. The Academy was the physical base of the postgraduate center and was a home for doctors coming to Metro City. The Academy was across the street from the Medical Center, and provided him with comfortable hotel facilities close to where he would be making daily ward rounds.

It was a pleasure to stay at the Academy, there were always other physicians there, old friends who picked the same two weeks every year. The hotel was excellent and his wife enjoyed the two weeks as much as he did. The shops, theatre, and restaurants made it a real holiday and she was enrolled in one of the adult discussion groups offered by the extension division of the University.

Although the Currys would be using the Academy as their base for these two weeks, he had been up several times during the year for the one-day seminars which went on there throughout the year. He was still enjoying the one-day program on coronary care. The Academy had audiotaped the program and all participants had received a cassette summarizing the program. Once a month the Academy sent out to the participants in the course an examination, and he had the stimulus of seeing where his code number appeared on the monthly grade report. This was done every month for six months after a course, and it really helped to fix new material in his mind.

One of the superb values of the Academy was the excellent audio-visual equipment and conference rooms. The permanent staff kept everything in working order and this was such improvement over the way it used to be when the meetings were held in hotels, when it seemed nothing ever worked and the room was never a real teaching room, but a mis-used Ballroom.

The small seminar room at the Academy was a special treat. It seated fifty in semicircle. The chairs were comfortable office chairs, the television cameras were hidden and unobtrusive. Audio tape cassettes were made of the high points and sent to his home. The hotel rooms had one channel on the television set which replayed the key lectures in the evening and a medical TV Guide was printed every week, listing what was on the evening program. Those same programs would be on the new closed circuit television program to which he was subscribing in Riverport next year.

The programs could be seen live in the daytime, too, if one just simply wanted to stretch out in his hotel room and un-wind.

It is interesting, Curry reflected, how many things go into making continuing education, and make it a happy treat. Here he was heading off for two weeks with his practice in steady hands, all expenses paid, his wife excited at the change and incidentally, just as tired as himself. The two weeks together would be a real rejuvenation for both of them. The Academy's physical fitness rooms were a major part of their two-week plan and the re-tooling of his body and spirits, he suspected, was an important as the professional experience.

The Medical Center had provided in the new school, personal areas for the physicians on sabbatical leave to base themselves. He would be with the same Docent team that he had joined last year and would have the same office.

The first year he had come back for his two-week experience, he had been worried, even tense, over how he might measure up when making rounds with the students. He had quickly found that the students were delighted with his ability to analyze the total patient and the sessions with the students had reminded him of how much he really did know about humans and their response to problems. The fact that the School's academic goal had been re-defined and stated clearly to be that of "preparing a man to be a physician" had made for a receptive orientation from the students.

Another thing that made the two weeks pleasant to anticipate was that he each year had come back to the same comprehensive health care unit, the Docent Team. The same group of full-time doctors, nurses, pharmacists, technicians, and assistants made the Docent Team seem like Homecoming each year. The fact that the same students were with the same Docent Team for four years gave him a chance to see them "grow up." In fact, he had first met young Cross as a senior student in this same Docent unit.

During the two weeks, he would make morning rounds with the group, with the senior Docent in charge. He then would have the rest of the day free to attend conferences, read in his office, work at the self-learning machines in the unit, and examine the new patients. He had three sessions with the students each week to discuss new patients.

The continuing education program of the Academy was completely co-ordinated with the undergraduate curriculum. For example, the Visiting Docent with the unit was the famous renal physiologist from Magna University and he was taking all of the students in Docent Teams A, B, and C through their exposure to human renal physiology. This would be videotaped in the "living theatre laboratory" of the School and these carefully prepared lecture-demonstrations would be available for replay for the students. The Visiting Docent also gave a full-day program at the Academy during his appointment at the University. It was similar to the one-day seminars which Curry had taken in coronary care; these went on regularly, four times a month.

The Visiting Docent also made teaching appearances at the community hospitals which participated in the Medical School's program. It was this total use of a visiting talent, as teacher for students, residents, and physicians, for community hospital staffs, and for Academy seminars which had really made the continuing education program possible in the first place. Not only was there a real and sensible dollar economy, but the really good teachers enjoyed the feeling they were being effectively used and having a material influence - rather than the usual jet trip halfway across the country to talk for 30 minutes to 50 doctors, and then on the plane again.

Another thing that had made the system work was that the Academy had invited the professional education societies in Metro City to come in as full partners in the program. For example, the local "Kidney" group was not only the co-sponsor of the visiting docent, but their education group had taken on the project of developing and grading the follow-up examination. One thing the entire education effort at Metro City had proved was that there really is enough talent and even money if you can just give everyone a chance to be usefully involved.

Curry was glad he was at the Medical Center for his two weeks. However, one of his friends always came back to a Docent Team at Mt. Minerva Hospital. Mt. Minerva is one of the several big, excellent community hospitals which fully shared the education effort of the Medical School. Pre-medical, medical, resident, and postgraduate medical teaching was all carried on at Mt. Minerva and the Academy coordinated the locum tenens-sabbatical leave program for them. Several small-town hospitals had developed a satellite arrangement with Mt. Minerva and one link of the closed circuit television system was based there. Curry's friend had had his own residency at Mt. Minerva, and he had been coming back for his sabbatical tour for five years and had four men in practice with him, all of whom had come through the contacts with the yearly visits.

Curry paused in the doorway of the office and glanced back at Cross, already on the phone talking to a patient. Cross waved and said: "Go on, enjoy yourself. I'll take care of the shop."

CONTINUING MEDICAL EDUCATION
ISSUES AND ANSWERS

JAMES Z. APPEL, M.D.

It is with mixed emotions that one accepts the assignment of the "anchor man" on a panel of speakers who are each to present different aspects of a central subject unless the boundaries are well defined beforehand. The assignment given me, "Issues and Answers", certainly has no defined boundaries. This is particularly disturbing when the preceding speakers have been assigned very fundamental "Issues" which must receive "Answers" if continuing education is going to be a very meaningful experience for the practicing physician.

However, I am not perturbed in the least. If I should repeat that which has already been said, he who first said it will be pleased and repetition leads to conviction. Should I flagrantly disagree with my respected colleagues on this panel, I will produce controversy and promote discussion, which is the purpose of this Conference.

Theoretically, the necessity for continuing education should not be an issue. It should be accepted by all as something essential for the continued good practice of medicine. Were we not repeatedly reminded when we were students in medical school that "Medicine is a lifetime of learning"? During our years of internship and residency, were we not warned how quickly we could become obsolete if we did not constantly keep up with the literature? Is it not traditional that young men and women enter the study of medicine in response to a "call" to be of service to mankind just as other young men and women respond to a "call" for the ministry? Should not the stimulation induced by such high moral motivation create a dedication to perfectionism that would make continuing education an integral part of the practice of medicine?

It seems that such idealistic principles, readily accepted by the embryo physician, too often become eroded away by many realistic factors and indeed alibis. While practically all physicians, today at least, pay lip service to continuing education, a fairly large minority fail to develop effective programs for themselves which will prevent their professional obsolescence.

There is another minority of physicians who seriously do all they can to keep up-to-date. Great sacrifices are made by them in doing this. But alas, their selection of educational mechanisms to accomplish this is poor and not very effective simply because there are not sufficient guidelines to assist them in charting their educational experience along a course that will truly meet their needs.

Most physicians are successful in "keeping up". More and more each year are demanding the opportunity. There are no accurate statistics to verify this assumption. One indication of the validity of this assumption is the increasing number of courses or programs that are being listed in the *Journal of the American Medical Association* each year. Until fairly recently, there was no way for the practicing physician to evaluate the course listed. Since 1964, the Council on Medical Education has accredited 86 institutions that provide more than 1,218 courses in continuing education, which amounts to more than 53% of all the courses listed. It is assumed that if the institution's general program for continuing education meets prescribed standards for accreditation, the institution will provide courses that have merit.

Putting aside the idealistic and theoretical reasons for combating physician obsolescence, there is real value to continuing education and the consequent improved quality of care. In spite of the political hay that was made of "health care is a right" a few years back and which even now is still reverberating, since the days of Hippocrates, the medical profession has always contended that health care is a right of every individual. But more than just health care is a right. Quality health care is a right. If not specifically spelled out in the Principles of Ethics of the profession, it is the fundamental purpose of the Principles. But this ethical right of quality health care has recently been reinforced by court decision when the old concept that the quality of health care rendered must meet local standards of care has been discarded. The courts now demand that the quality of care must meet national standards, regardless of local practices.

Inflation has affected the practice of medicine and the securing of health care in a very dramatic manner. It has boosted the cost of health care so high, along with other fiscal factors, that it has become increasingly difficult for patients to finance their needs in this respect. It has focused the public eye on health care, how it is administered, how it is delivered, how it is financed and how it is regulated or non-regulated. All health care is expensive today. But poor medical care is the most expensive in dollars, in disability, and at times in the unecessary cost of life itself.

The rendering of quality health care is of great value to the practicing physician, not only in dollars, but also because of the great psychological satisfaction that accrues for a job well done. It is a case of personal ego versus dollars. In such a conflict only the most callous money hungry physician will choose the dollars.

The provision of quality service will protect professional freedome more effectively than any political lobbying program or public relations promotion. It demonstrates professional responsibility which generates respect and confidence in the eyes of the public so there is less interest in control and regulation.

Finally, with the increased use of third-party fiscal agents, be they pre-payment plans, insurance plans or government plans, there naturally developes concern about costs, patient satisfaction, and quality of goods purchased in behalf of the beneficiaries. It is recognized that where services are the products, the expertise of the providers of the services establishes the quality of the product. Great interest becomes generated in any method that will maintain and improve the qualification of the providers.

In view of all that has been said, certainly the need for continuing education cannot be an issue. The answers are obvious. The real issue that relates to the general subject of continuing education is "how effective is it in combating obsolescence?" The proliferation of ways and means of continuing education would indicate that it has been considered effective. However, the quality of health care rendered in this nation is not all that is desired, and it varies considerably throughout the nation. We can say this even though we do not have the yardsticks for measuring quality. Furthermore, we have not as yet developed methods by which we can evaluate the effectiveness of the programs in changing the behavior of the physician in his practice of medicine. How can we be sure that a given program has produced improvement in the care rendered by a physician? It is assumed that the learning process will improve one's performance. How valid is this assumption?

Another question asked is how relevant are the various programs of continuing education to the intellectual needs of the physician already in the practice of medicine? In undergraduate and postgraduate education we start the educational program on an almost completely blank page. We can use a shotgun approach that will cover all aspects of medicine, gradually concentrating in greater and greater depth as we proceed into the specialties and subspecialties. In continuing education we are attempting to meet specific needs that have developed in an already educated and experienced practicing physician. Individual needs will vary. Continuing education must be programmed to meet these needs. Programs that do not meet the needs are a waste of time for the busy physician and tend to discourage him from further efforts to improve his know-how.

Efforts have been made and are being made to determine the specific needs and to determine the effectiveness of programs. The ill-fated Utah Study, sponsored by the American Medical Association, was primarily intended to determine the level of knowledge and thus non-knowledge of a thousand doctors distributed throughout a state and distributed in thickly populated metropolitan centers, as well as sparsely settled rural areas. Primarily because of the techniques used, the statistical validity of the primary phase of the study became questionable. However, valuable information was gained about some physicians. It is hoped that, benefiting from the errors of construction of this study, other studies with more validity will be instituted. It was the long-range plan of this study to develop core curricula for programs of education which would meet the needs of those physicians who took part in the study. The physicians would undertake the specifically designed educational program and at a later date undergo a resurvey.

The self-evaluation study of the American College of Physicians was designed to permit those internists who were interested to take an examination which would point out to the examinees their deficiencies in medical knowledge. It was assumed the physician would then take steps to correct these weak spots in his medical acumen. A second self-evaluation examination would then become available by which each physician could determine how well his educational experience corrected his weaknesses.

How significant is any examination in revealing the extent one uses the knowledge gained from an educational program in his practice of medicine? What and how much behavioral change does exposure to a teaching program produce in the student-physician? To circumvent these questions, and to arrive at a valid evaluation of the effectiveness of a program in producing behavioral changes, the peer review mechanism has been utilized to determine the needs of a group of physicians, to define relevant subjects for teaching, to design and produce educational programs on these subjects, and by follow-up peer review to determine the changes in performance that might be attributable to the program.

In order to be successful, three elements of peer review quickly come to mind that must receive careful attention. Complete objectivity must be exercised by the reviewers at all times. The knowledge and skill of the reviewers as exemplified by the quality of the service they render their patients must be adequate so that they can pass responsible judgments on their colleagues. The criteria used to evaluate quality of care must be sound.

Maintaining objectivity is easier in large groups than in small neighborly groups. Remoteness of the reviewing instrument also promotes objectivity. Regionalization by developing an appeal and supervisory organization, say on a state, county and institutional basis, has been helpful. The development of special organizations such as foundations, professionally sponsored and controlled, has worked very well but needs more refinement. Certainly the new specialist, the director of medical education, particularly one who is full-time, has helped in assuring at least some objectivity.

If the level of care rendered by a hospital staff or county society as a whole is below acceptable standards, it becomes very difficult for such a group to select reviewers who will be able to detect poor quality care. In such cases some supervision, advice and guidance is needed.

At the present time, there are no nationally recognized criteria upon which quality care can be evaluated. There are quite a few outlines of criteria available, but none of them have really been given a good test for reliability. Perhaps this is good. Too rigid standards or criteria would freeze out innovation and stifle improvement. On the other hand, anyone who evaluates the care rendered to an ill person must base his or her decision on elements which he considers essential for good care. Research is being done on evaluating sets of criteria. With the inclusion of the requirement of peer review organization in pending social legislation and the placing the responsibility of setting standards for such organizations in the Department of HEW, the federal government has become very interested in such studies. It is providing cooperation and assistance for some studies and sponsorship for others.

Another issue that confronts the broad subject of continuing education is the methodology used. Continuing education has been utilized like the churches have been - too often those who need its benefits the least, largely constitute the congregation, and those who need it most are conspicuous by their absence. In order to overcome the many arguments used to explain this behavior of physicians, namely time. distance distance cost in loss of income and securing substitutes, a wide variety of techniques have been developed. The formal type of organized program of instruction utilizing lectures, seminars, workshops, grand rounds, has passed the acid test of long time study and research in education so that it is without doubt the most efficient and effective method. However, it is subject to the several criticisms just listed. Too often such formal courses are not relevant to the needs of the practicing physician looking for help. Many times good construction and presentation are lacking. Since they are directed to already educated and experienced physicians, they cannot be programmed like the curricula used in undergraduate and graduate education. In this respect, they do suffer from the absence in many courses of student-physician participation and patient-oriented, as opposed to lecture or textbook oriented, instruction which have been found so valuable in other forms of medical education.

Steps have been taken to surmount these latter criticisms. By developing special faculties in continuing education at our medical centers, the design has improved, presentation is better, there is an increasing amount of physician participation, and bedside teaching has been utilized to a greater extent. In-hospital residencies have become available for practicing physicians in a few educational centers.

One often overlooked advantage of the formal course method of instruction is that such courses are amenable to evaluation. This is of great value to the student-physician in guiding him in his selection of programs. The American Medical Association, in establishing the Physician's Recognition Award, predicted the eligibility for receiving the Award upon the completion of a certain number of hours of education in "required" activities. Included in this category of required activities are courses of instruction that are included in the programs provided by institutions which have been accredited by the AMA for their program of continuing education. As more and more institutions are accredited, it is anticipated that their programs will make up the bulk of required credits. Of course, there is another purpose to the AMA's program of accreditation. It is hoped that this program will upgrade the quality of courses provided in a similar way that it is believed the accreditation of medical schools has stimulated improvement in undergraduate medical education.

Many physicians are able to keep well abreast of advances in medicine through self-programmed study of medical literature. This method has always been regarded as valuable if not essential regardless of the use or non-use of the formal course method. It was not too long ago that the American Medical Association had no dues but did offer a special form of membership called a "Fellowship" to those members who subscribed to the official Journals of the Association. It was assumed that if a physician subscribed to a periodical, he would read and study it. However, it soon became apparent that there was some question as to the validity of this assumption. With the rising costs of administering and programming the American Medical Association, and with increasing doubt as to the effectiveness of the "Fellowship" program, the latter was dropped and dues were instituted. However, the value of the Journals as instrumental tools was still recognized and therefore, the payment of dues included the receiving of *JAMA*, and one other of the Association's Journals, at least in the hope that they would be studied.

The same criticism is applicable to other forms of self-education which are not accompanied by some form of testing or evaluation of the effectiveness of the educational experience. A very popular program in this category is Audio-Digest and its many variations. This problem is under study by the AMA Board of Trustees Committee on Continuing Medical Education. The Committee believes that such methods of learning have merit and should receive recognition. However, at the present time, there is no method of evaluating their effectiveness in the individual physician.

The development and increasing use of "hardware" in education has created much excitement among practicing physicians and educators. Hardware can increase the geographical area that can be covered by any method of teaching. Indeed, it can tear down the walls of the university that limit student numbers. The two-way radio, open or closed circuit television, scrambled television and film libraries are in common use today. Some of these, coupled with special telephone circuits, become two-way. Such devices are able to bring the professor and student into instant dialogue almost as if they were in a formal lecture hall. Some of these are centered in local high schools, as in South Carolina, or community hospitals. Some can be brought into the physician's home or office at a convenient time so they do not interrupt his services to his patients. Tapes can be played anywhere, including the physician's automobile, though I sometimes wonder what such practices do to driving safety. As yet, Ralph Nader has not made any comments on this to my knowledge.

Combining the typewriter, the television set, the computer and the telephone, it becomes possible to obtain from centers of medicine consultations on perplexing problems. Consultation as a form of medical education has often been overlooked and ignored.

By the development of the Lister Hill National Center for Biomedical Communications, the Congress of the United States has given recognition to the importance of improving communications as a lever in upgrading the quality of care in the nation. This is the first step in placing a high priority rating on the continuing education of physicians.

Presently, the Center is working on a very restricted budget. Therefore "it has selected services where the cost of either the information resources or the necessary equipment or both are already being borne by external groups. The planned role of the Center is to provide the necessary interface - either software or hardware - to make the service available to a selected customer group, to arrange for the necessary interconnections between resources and customers, to ensure that the service and its use are understood by the customer, to monitor and evaluate the service, to determine the realistic costs of maintaining the service and the proper assignment of operational responsibility and to recommend follow-on courses of action." Services listed for study include the extension of MEDLARS by the AIM-TWX project, the Alaska-Pacific project, and the audio-medical information center.

The AIM-TWX system is an experimental project which provides rapid responsive searching of the medical literature. Bibliographic information for the last five years in 100 journals in clinical medicine, which includes those in the new *Abridged Index Medicus*, will be stored in a computer in Santa Monica, California. By use of a TWX terminal or a teletype terminal connected to a telephone network, a physician will be able to search the bibliographic information stored in the computer. The Lister Hill Center will finance the computer costs and the user will pay terminal and communications costs.

The Alaska-Pacific Communications project will utilize satellite transmissions to send medical information to remote areas. This will include voice, slow scan TV and color facsimile so that the system can be used as a data base, as well as for the interpretation of x-ray films, EKG's, etc.

The audio-medical information service will give wide geographic access to selected audio tapes on pertinent subjects such as poison control and other medical problems.

The Lister Hill Center is also evaluating micro-projectors, casete recorders and typewriters which can be plugged into the telephone or TV set for communication with computers. In the latter case, it has been estimated that the rental charge is $120 per month, but if 10,000 are used, it will be $30 per month. Presently, the purchase price is $2,500, but if 10,000 are sold, this would come down to 600.

Continuing education is expensive. The rising costs of living along with the consequent increase in academic salaries, and the greater use of expensive hardware has, and will contribute, to further increases in tuition fees. At present these costs are either paid directl by the ill patient in the form of increased hospital costs, or ar indirectly borne by the patient in increased physicians' fees and salaries. As mentioned before, costs amount to more than tuitio and travel. To these must often be added the loss of income whie absent from practice and the sums paid to some physician who take care of the practice.

Ordinarily, costs should be borne by those who benefit from the product purchased. Undoubtedly the practicing physician benefits by participating in continuing education, not only in satisfaction gained from better practice, but also by an increase in his income that should accrue if the educational experience is translated into improved service. The patient benefits by the improved care he receives. But people of the community who are not ill also gain by the assurance that quality care is available when and if they might need it. The fiscal agents such as insurance and government benefit because quality care in the long run is the least expensive care.

In view of the foregoing, how should the cost of continuing education be met? At present, it is the financial responsibility of the physician and perhaps it should be. However, it may well be that these costs might act as a deterrant to some physicians from participating in continuing education. The American Hospital Association has proposed that one to three percent of the gross income of hospitals should be allocated to in-hospital education. This may not be enough and certainly will be resented by the ill people who are not at all interested in any further increases in the cost of their health care. Some other form of subsidization might have to be considered, particularly if continuing education becomes mandatory by law.

The designing of curricula and the presentation of a teaching program should be done by those best versed in educational techniques if the product is to be of any value. Medical educational insttutions do not have the personnel to do this on any large scale. Thus, faculties must be increased. Are we going to deplete further the already inadequate supply of practicing physicians to increase medical faculties? Much of the hardware mentioned previously will multiply the effectiveness of existing faculty many times over. Also, in most community hospitals there are staff physicians who have the potential of being good educators. By affiliation of a community hospital with a medical school faculty, these potential educators can blossom forth as good teachers. They can be used by the community hospital staff as the nucleus of the hospital faculty. They are in a better position to intimately know the educational needs of their colleagues on the staff than any professor in a distant medical school. This is being done and, where well done, has been successful.

There seems to be increasing support for the idea that it is the duty of the community hospital to accept the responsibility as the educational center for the physicians on its staff. This appears to be both logical and practical. However, there are thousands of physicians who have no hospital affiliation. They need education too. Therefore, it is incumbent upon community hospitals that support educational programs for practicing physicians to open their doors to all physicians in the area with no differential in costs between non-staff and staff physicians. Many, if not most hospitals do this. All should.

Many community hospitals cannot and should not operate alone. They should establish some relationship with a teaching center. In other words, regionalization is important so that the best talent and guidance available is constantly at hand. In many areas the national Regional Medical Programs are doing an excellent job in catalyzing such regional organization for education. In many areas it has been spontaneous.

The final issue to be discussed is voluntary versus compulsory continuing education. Certainly the ideal would be voluntary. It would be ideal because to be successful all physicians would make any and all sacrifices necessary in order to avail themselves of it. You know and I know that such is not being realistic. Certainly every effort should be made to attempt to reach this ideal by stimulating the motivation needed to bring physicians into the lifetime-of-learning process. Undoubtedly such a program cannot be 100% successful. Perhaps if there were not a shortage of physicians this would not be so important. The public would be in a better position to use discretion as to whom they select for their medical needs. At present they have neither the knowledge nor the guidelines to make such a choice. Furthermore, because of the inadequate distribution of physicians, not only in the rural areas but also in the large metropolitan cities, many patients have no choice at all.

In order to improve the abilities of the hardcore non-motivated physician who is sorely needed in our present short supply, it becomes necessary that some form of coercion be exercised upon him. This can take either one or both of two forms. Incentives can be provided for the physician who avails himself of the opportunities available for self-improvement. In some respects, this is the purpose of the AMA Physician's Recognition Award. Should this award ever become as prestigious as Board Certification as is hoped, it will certainly have the same effect. However, it has an advantage over the Board Certification in that the latter has been life certification. The Award involves repeatedly meeting its requirements every three years.

One specialty society, one state society, several county societies and quite a few hospital staffs have in one way or another made evidence of continuing education a requirement for continued membership. On the surface this is good. But it is only good if the sponsoring organization places a higher priority on continuing education than on continuing membership. If it does otherwise, its required credits become too easy and ridiculous as evidence of education. However, this technique should not be in any way ignored. Properly administered, this approach has great potential. The program of the Oregon State Medical Society is well organized and programmed. It bears watching.

A potential weakness inherent in the above membership requirement is that physicians do very well indeed without any county, state or national medical association membership, and also without membership in any specialty society. Even lack of Board Certification does not inhibit a physician from making a good living and having a good practice. Of course, most specialists need hospital affiliation. However, staff membership cannot be contingent upon medical association membership. Perhaps if medical associations demonstrate great responsibility in this regard, and place the highest priority on self-improvement, membership will mean more in the making of staff appointments.

A final alternative, the big stick, is continuing education made mandatory by legislative action. This can take one of two forms. The first form is periodic relicensure. There is some argument in favor of this approach. At present, one examination, taken immediately prior to practicing medicine or entering a residency, gives legal sanction to a life-time of practice, regardless of the educational behavior of the physician from that point on. Thus, perhaps the states should take repeated looks at the extent of knowledge of the physicians who come under their respective jurisdiction. However, there is some validity to the question as to the effectiveness of an examination in measuring anyone's ability. Certainly evidence of continuous continuing education is a better yardstick.

The second form of a stick cannot be used at the present time. However, with the almost inevitableness of some form of federally regulated national health insurance, the incorporation in the law of the requirement to show evidence of continuing education for eligibility to receive payment could be quite effective. If such does come to pass, at least at first, government would have to be quite liberal in its definition of satisfactory education. It is certainly hoped that this will not become necessary.

DEVELOPING A TEACHING FACULTY AT COMMUNITY HOSPITALS

MAX MICHAEL, JR., M.D.

Considerable time, effort and money have been expended in continuing education, and particularly in the exploitation of the newer electronic marvels - TV, dial access, the radio conference, computer based instruction, to name only a few.

We have attempted to develop a program based on premises that are really not new. They have been often stated and were enunciated yesterday, loudly and clearly. The phrases that are most cogent vis-a-vis our approach are - "learning must be from the patient at hand"; "the talent and resources in the practicing community must be utilized"; "we cannot have continuing education confined within the ivory walls"; "the university should furnish guidance"; "we need to take a new look at some old methods". Basically, we wish to utilize the traditional hospital conferences for an educational experience in the true sense of the word, developing members of the practicing community as the local faculty. A survey we conducted concerning the opinion of the practicing physicians as to the efficacy of the various modalities for their continuing education coincided quite significantly with the study done by the California Medical Association. This indicated that hospital conferences fall behind seminars, courses, books and journals as modalities in continuing education. What we then are attempting to do is to utilize existing hospital functions in a more meaningful program of continuing education - in essence, we would like to increase their acceptance and efficacy.

There are certain hang-ups in the development of this concept. These can be enumerated thusly - the time the busy practitioner has to give or is willing to give for his continuing education; his unfamiliarity with certain basic educational concepts; his insecurity toward assuming the role of teacher; the oft quoted cliche, "A prophet is without honor in his home town".

For the faculty we have selected those individuals who have displayed leadership roles in educational affairs - in the hospitals and in the graduate programs. Three exercises have been conducted, aimed at "teaching the teacher to teach". The first was a half-day session on the learning process at which an educational consultant presented current concepts. There was surprisingly good give and take during the Question and Answer period. The second was a more pragmatic program on the use of audiovisual materials. The third was a "mini-retreat" - an all day program, complete with workshops, discussion groups and plenary sessions. Its success can be attested to by the fact that it was held in an oceanfront motel on a lovely spring day. Of the 35 participants, only two left before it was over - their beepers went off!! Parenthetically it can be stated without fear of contradiction that as far as educational conferences are concerned, the beepers have been the most destructive and disruptive devices that have entered the hospital field. How disconcerting it is to be in the midst of issuing some significant pearls of wisdom only to have the train of thought disrupted by a beeper as it squawks out data that most likely could wait till the end of the hour.

For a vehicle we have chosen interdisciplinary conferences. Topics were chosen by our faculty based on what they considered to be their needs - such areas as Antibiotic Therapy - Demineralization of Bones - Diabetes and Pregnancy - have been approached. You can see how the audit can be utilized to arrive at topics in a more convincing fashion.

Contrary to the usual staff conference - there was planning for these. Topics and faculty were chosen at least four weeks ahead of time. The faculty for the particular conference met to determine format, to select patients to be presented - and we always began with patient presentations - and to plan their presentations. This is where we step in and try to save the physician's time. The libarian furnished each participant with a bibliography and with pertinent photocopies for his presentation. Each faculty member was approached to help him develop audiovisual materials. Then came attempts at dressing up the conference - attempts toward making them something "big". All members of the county society are mailed programs listing subject and participants. These are printed - not mimeographed. Posters were placed on bulletin boards announcing the topics and faculty - and they are called just that.

Finally, the conferences - some have been excellent, some fair. As we evaluate them, the degree of preparation is often a big determinant to the success. A vignette from a recent one explains I think the atmosphere we are attempting to create. The moderator called my secretary several days before the conference asking for the curriculum vitae of those participating. Mind you - these are our local practitioners. He introduced each speaker as if he were a visiting fireman - curriculum vitae and all. I think he was telling us that a prophet can be honored in his home town.

Are these conferences good? How can they be evaluated? I don't know. The only measure of success we can attest to is attendance (excellent) and testimonials (usually of a high order). But whether we have changed behavior is hard to say. We have not gone into this aspect - and it needs doing.

As for the involvement of the University - members of its Department of Medical Education in the Dental School help in our planning. We are beginning to give clinical faculty appointments to Jacksonville physicians for active participation and leadership in educational programs - continuing as well as graduate. And at our conferences we have a resource person from the College. He is the visiting fireman - but usually a silent one. As several of these have commented, "you really have some superb teachers here".

Let me read some comments from a recent unstructured CPC furnished by our educational consultant.

> "The conference was announced for 8:00 - 9:00 AM. The principals participating in the conference arrived after 8:00 with one exception. It was then necessary to arrange materials in preparation for presentation. The conferees drifted in still at a later time. Coffee and a roll delayed the beginning time still more and the actual beginning was at 8:15, not really a serious delay but one that was sorely needed at the end of the scheduled hour, if the dismissal was as scheduled, which it was."
>
> "The conference's working level was totally in the cognitive domain, nearly all at the level of analysis and synthesis. This is an excellent teaching level, particularly for men of medicine. It must be remembered though that not every conferee functioned at this level and it might have been well for instruction to occasionally function at the level of knowledge. The basic assumption, which may have been false, made by the discussor is that all of the conferees were as well-versed on the elements which make the case as he was after he had spent presumably many hours working up his discussion."
>
> "The voice of the discussor was clear. He enunciated clearly and distinctly. He spoke very fast, which is excellent for review, but not so for teaching. He had a distinct tendency to speak to his charts and to the rostrum. The acoustics of a room just love to play demon with such an instructor. Actually in the room in which the conference was held he was effective."
>
> "The pathological slides were excellent. The presentation was far too rushed. Just visuals without appropriate comment is ineffective. The gentleman who did the presenting of this phase was on the spot by having it called to his attention of the lateness of the hour but "of course we don't want you to rush"."
>
> "No type of evaluative instrument was used to indicate how effective the participating conferees were as learners. It is accepted that those who had a responsibility for the preparation of materials, presenting and discussing learned much, but what about the conferees seated at tables? Is there even a possibility that some (maybe only one) learned a wrong thing? Strange as it seems, this is always a distinct possibility. The conference would have been stronger with an evaluation of some kind."

Aren't we aware of these thoughts - but what do we do about them? This type of information can be utilized in all conferences and will help in planning meaningful learning experiences.

Hospital based conferences can indeed be made a most significant - if not the most significant part of continuing education. As has been stressed by others - it furnishes the true continuum - an evaluation of day-to-day experience. They must be planned and "dressed up". We can find the teachers in our midst but they need help - and those that are the leaders should be treated with the deference given visiting firemen, for they almost qualify. You will recall the visiting fireman is the person of uncertain parentage, with slides, and from out of town - all of our faculty are local.

SELF-ASSESSMENT AND THE PROFESSIONAL SOCIETY

WILLIAM O. ROBERTSON, M.D.

Traditionally, man's formal learning programs have been firmly circumscribed during his formative years, left to his own devices during his maturity, and ignored in later life. Put in simpler terms, the primary grade school has a prescribed curriculum; the University's graduate program permits a wide breadth of course selection by the learner, and "adult education" persists largely as entertainment - or immediate payoff programs.

Actually, the past few decades have seen some revisions in this traditional approach. The primary schools are permitting some variation with attention to student choice. Graduate education - particularly in the medical field - has seen a burgeoning of designed courses - with some hint that attempts at enforced attendance might be hiding over the horizons. Regardless of direction, visible change is evident to all concerned in the process of education - and in particular of medical education - be it undergraduate, graduate or continuing.

As part of this visible change is an increasing awareness of the necessity for the learner to be in on the determination of his own learning objectives. Refinement of this participatory involvement has lead to several professional organizations developing a "self-assessment" program - making it available to its membership as a tool for determining personal education needs. Let me describe how your pediatric colleagues have gone about this process.

Over the years the Academy of Pediatrics has maintained a Committee on Medical Education. It has wrestled with various issues of continuing education. Until two years ago, it has never been able to pin an answer to that question, "Continuing education for what?" Following a number of meetings under the guidance of Bill Daeschner and perceiving the response of other physician groups to a self-assessment-of-needs program, the Committee decided to develop such a tool for its membership. Early on, enthusiasm raged for evolving extensive and expensive problem-solving or patient-management problems; for a number of reasons, the Committee eventually reverted to more conventional approaches to helping pediatricians assess their competence - as measured by knowledge or manipulation of knowledge - i.e., reasoning processes.

Once the decision had been made to develop some type of self-examination for the members, the question loomed, "Who will determine the topic content?" Concern was obvious that such might be left to the academicians and ergo be non-relevant. As a consequence, nation-wide chapter participation was developed with each of our nine regions contributing three participants - two practicing pediatricians and one academician - all of whom were requested to develop questions on topics they felt were relevant to the moving forefront of medicine - or its eternal verities. The Academy's Committee on Medical Education's nine members accepted the task of developing some patient-management problems. Working with the National Board of Medical Examiners, once a group of questions reached a critical mass, they were given a quick editorial review and distributed among the group for reactions and reconsiderations. A number of small group meetings were held at which the concept of a self-assessment tool was reviewed and the details of the contents argued out - both questions and answers! Gradually, an initial pool exceeding 1,000 items was filtered down to approximately 400. Editorial refinements were added; visual cues and clues were added. The eventual tool began to take form.

During our initial deliberations, the Committee on Medical Education saw the tool not simply as enabling the practitioner to make an assessment of his own strengths and weaknesses as compared, so to speak, to some group-determined national guideline, but also as a technique of generating summary data about the strengths and weaknesses of pediatricians the nation over. At this point, an ideological conflict developed between the Committee and the National Board of Medical Examiners. While a number of members of the Committee remain quite comfortable with the concept that the self-assessment program could measure the individual practitioner's knowledge of facts or his ability (or his motivation) to look up those facts, the National Board of Medical Examiners preferred to "evermore precisely" limit its focus on the knowledge retention *per se*. As a consequence, they were most reluctant to generate any summary data which could be used for item analyses except under stringently controlled conditions. This confrontation has not been ideally resolved. No summary data will be prepared by the Board. (In their stead, a request from the Academy of the individual participants - permitting full retention of anonymity - will seek the answer sheets so that the data can be generated after the fact!)

Speaking of anonymity, the eventual "self-assessment booklets" - three in number with 374 items - were ready for distribution in May, 1971. They were mailed out to those members of the Academy who had indicated a $25 interest in the program. These numbered in excess of 2,200. Allowing some six weeks for completion, the answer sheet was to be returned to the National Board of Medical Examiners via a bonded intermediary to assure anonymity. After marking by the National Board, the sheets were to be returned to the individual physician - also via the bonded intermediary - along with a correct answer sheet and indication of the acceptable answers plus an appropriate bibliography for use by the practitioner to catch up on concepts. Some 1,400 participants chose to return their sheets for automatic answering; some 800 did their own.

We - along with the internists, the psychiatrists, and other groups - consider this approach somewhat of a quantum step in making medical education truly a life-long learning process to be approached on other than a strictly random (or brownian movement) basis. Here, the involved practitioner can - *at his own pace* - react to a series of items judged by his peers as being important. He can first and foremost decide if his judgment of importance is equated with his peers. Assuming that it is, he can then test his memory or his logic and his ability to ferret out answers from those devices he uses in his everyday life. Once having done so, he's able to receive an objective indication of his relative success - and then guidance - again for his own acceptance or rejection - about how he is to proceed. All in all, the process permits individualization of learning. It insists on the practitioner's having the critical voice in determining his learning objectives. And it allows not simply for the customary memory test - that is, measure of the product of the man's memory - but a test of a real life function - an assessment of the process of problem solving as he carries it out in his own world.

Moreover the technique permits the generating of summary data for a national profile. While perhaps it is somewhat early to tout the process as a panacea, it is not at all premature to consider the implications involved - from an educational, a professional and even a political vantage point. Yet another project "that couldn't be done" has been accomplished - apparently to the benefit of all concerned.

THE POSTGRADUATE MEDICAL INSTITUTE PROGRAM IN CONTINUING MEDICAL EDUCATION

NORMAN S. STEARNS, M.D.

A few physicians including officers of the Massachusetts Medical Society created Postgraduate Medical Institute in 1953 as a non-profit educational corporation, the objectives of which were defined 17 years ago by its first president, Doctor Laurence Ellis, as follows:

> It will coordinate activities of all agencies concerned with postgraduate education and in particular it will call in the expert help of the medical schools of the Commonwealth. It will conduct courses carefully planned for the needs of practicing physicians but it will in no way interfere with or compete with the teaching activities of established groups that wish to carry on their own programs. It is prepared to offer assistance to community hospitals or similar groups who wish to develop local programs. Finally, it will be in a position to experiment with and find various new teaching techniques in this most difficult of fields.

PMI experience indicates that an independent but widely supported central agency can conceive, coordinate, effect, and sustain active programs of continuing education involving large numbers of physicians and encompassing large geographic areas.

The corporation of PMI is composed of those persons who are the elected executive councilors of the Massachusetts Medical Society, one from each district in the state, plus the officers. Thus, the Institute is responsible to the Society but it operates independently by authority given to its own Board of Directors under its by-laws.

Thirty-six board members include representatives of five medical schools, the state health departments and the medical societies of Massachusetts, New Hampshire, and Rhode Island. A majority are members of the Massachusetts Medical Society and all are elected by the corporators. PMI reports regularly to the Society through the Committee on Education or directly in published proceedings of the Council.

Operational activities of PMI are carried out by a paid professional staff. All consultants and teaching faculty in PMI programs are paid honoraria for their services. Basic financial support for PMI comes from many sources including the Massachusetts Medical Society, National Institutes of Health, Tri-State RMP and a number of other private and governmental agencies and institutions including community hospitals that it services. It should be emphasized that PMI has no faculty of its own but utilizes faculty from all teaching institutions in the area. With rare exceptions PMI solicits faculty participants directly and not through any specific school, hospital or clinic office.

Since its inception, PMI has provided a variety of teaching programs including panels, lectures, and grand round case discussions. In 1961 the Institute was sponsoring 11 regional courses, a Boston Course in Basic Science and portions of the Albany Medical College two-way radio conference series. Financial support for most programs was provided by fees paid by individual physicians. Post war demand for courses by physicians returning to practice had been satisfied and interest in existing programs waned. Decline of interest was attributed in part to failure to relate lectures to community hospital staff education needs, failure to provide administrative support at the local level, and failure to provide educational formats to supplement isolated lectures. These factors prompted renewed efforts by PMI beginning in 1961. The primary objective of this effort was to use educational consultation to encourage community hospitals and their professional staffs to collectively develop their own coordinated programs. The basis of the approach was to stress local involvement in identification of local strengths and weaknesses, and ultimate planning and execution of programs which use a variety of appropriate educational techniques.

From 1961 to 1967 PMI developed contacts with 55 hospitals, 42 of which actually initiated some form of PMI sponsored program. Attention to in-hospital program development stimulated by consultation had become the primary concern of the Institute.

In 1967 the Public Health Service Divison of Physician Manpower recognized the potential for rapidly expanding PMI's consultation services to community hospitals using additional part-time consultants and contracted with the Institute to study the impact of educational consultation services on the development of programs in 40 consulted hospitals as compared with 40 non-consulted hospitals.

Sixteen physician consultants (mostly academicians) visited and made a variety of recommendations directed toward development of community hospital education resources including financing, personnel, facilities, and planning mechanisms and procedures. PMI also designed and implemented a series of training programs for the consultants as well as for 34 local program directors to enhance both the effectiveness of the consultants and of the local directors in planning and carrying out programs within the hospitals.

The study results supported the fundamental efficacy of the consultation process. That is, consultation services by PMI trained consultants affected the implementation of elements of physician education programs in a significant and positive way.

Based on experience during the three year study period, PMI has devised an eight step Systematic Approach to Educational Program

Development which is logical, sequential and comprehensive. This approach is a model that any medical educator can use as a guide to develop hospital education programs from the point of conception to design and implementation. The approach encourages program changes based upon repeated realistic assessment of accomplishments and failures.

The eight steps are:

1. Marshall local commitment, support and personnel
2. State overall goals
3. Identify needs based upon hospital and medical staff data
4. Formulate objectives relative to defined needs
5. Consider potential elements of educational programming
6. Determine local resources and needed supplemental resources
7. Structure and implement program to meet stated objectives utilizing relevant resources
8. Evaluate program relative to objectives and goals

Utilizing this sytematic approach as a framework, a manual has been prepared which details sound principles of education program development in a "how to do it" fashion. Means are currently being sought to test the manual's effectiveness and to make it generally available for use by DME's, education committees, and administrators in community hospitals and by state medical societies or others concerned with aiding hospitals develop education programs of their own.

In addition to hospital consultation efforts, PMI has been involved in many other activities. Among these were the production, with the Bingham Associates Fund, of Boston Medical Reports television series for physicians, and the use of live two-way telephone conferences involving medical center faculty and community hospital practitioners to complement pre-taped TV presentations. The telephone conferences were also used for consultations and teaching purposes independent of TV programs. While these programs are no longer broadcast locally, "BMR" TV tapes or 16 mm kinescopes are available upon request from the National Library of Medicine Audio-Visual Center, Atlanta, Georgia.

PMI has produced three annual serices of family practice "Core Content Review Self-Assessment Examinations" which have been taken by more than 6,000 physicians in 40 states. Each year 500 questions, answers, annotations which emphasize teaching aspects of the questions, and bibliographic references are prepared by PMI for this joint effort with the Connecticut and Ohio Academies of General Practice. Examinations are available to all physicians at minimum cost.

One day teaching symposia have been produced by PMI for a number of medical organizations as special projects.

PMI is also working with a committee of the Massachusetts Medical Society to help introduce a program which hopes to bring practitioners back to university hospitals for four or more weeks of "advanced clinical education" experience. PMI's role in this project is supported by the Tri-State RMP.

Another project that Tri-State RMP is supporting is a pilot study to test the practicality of creating an ongoing central registry of educational programs available to practitioners. By being more selective in screening and categorizing its listings this registry should be more valuable to practitioners than PMI's previous publication "What Goes On."

Creation of a Core Medical Library for doctors practicing in community hospitals and a Core Nursing Library for nurse practitioners have been important steps in the PMI - New England Regional Medical Library Service (NERMLS) library development program to improve inadequate libraries in community hospitals. More recently PMI has created an "Integrated Health Science Core Library for Physicians, Nurses, and Allied Health Practitioners."* The core collections of books and journals are based upon recommendations from large samples of specialists. These collections are being recommended as a basic stimulus to encourage development of the library as the health learning center of the hospital.

To date, 46 New England hospitals have implemented the medical core, and 61 hospital-sponsored persons have been trained as library supervisors at five-day library training institutes co-sponsored by PMI and NERMLS. A recent nationwide survey indicates that 21 of 24 responding RMP's and seven of ten responding Regional Medical Libraries are using the core library concept in some aspect of their own library development programs. The core library concept is that all major areas of health care practice be covered in a minimal number of books and journals; that selections be authoritative, current and relevant to practice; that all materials be readily accessible clearly labelled and logically arranged, and that the facility be supervised by a person trained to provide essential library services. PMI's library activities are also supported in part by Tri-State RMP and by the National Library of Medicine through the New England Regional Medical Library Service.

To help busy physicians glean from the literature information pertinent to their specific practices, PMI has initiated a Public Health Service-sponsored study to establish a system of criteria to differentially assess the clinical relevance of journal articles to general practitioners, internists, pediatricians, obstetricians, and general surgeons. If valid criteria can be established by a large group of cooperating journal editors, academicians, and practitioners, attempts will be made to identify clinically relevant articles using established criteria as an aid to practitioners confronted by an overwhelming volume of published material.

As an offshoot of the Institute's efforts to provide educational consultation to community hospitals, PMI is conducting a pilot study in which its consultation is geared to poverty related problems of the community served by the hospital. Utilizing interdisciplinary team consultation provided by physicians and behavioral scientists, PMI is attempting to stimulate the staffs of four hospitals to identify the special health problems and need of the poor population in their communities and then develop educational and service programs designed to meet these needs.

---

* In press, New England Journal of Medicine

Finally, PMI continues to provide about 300 in person lecture or grand round teaching sessions for more than 30 community hospitals and a number of health agencies each year. PMI is accredited by the Council on Medical Education of the American Medical Association, and its teaching sessions are approved for Category I credit by the American Academy of General Practice.

This paper has highlighted PMI accomplishments as measured in terms of numbers of activities and numbers of hospitals involved. We are impressed that over 1,500 physicians annually respond to our various in-person educational activities. This figure does not, of course, include the large number that take our self-assessment exams or watch tapes of our television programs. Numbers, however, are only surface indicators. They do not show the difficulties encountered, efforts expended or experiences in terms of behavioral change in patient care by physicians, nurses, or institutions. In this regard, we recognize behavioral change leading to improved patient care as the ultimate demonstration of accomplishment, but we are not dissatisfied with change that demonstrates only a renewed willingness on the part of physicians to help create and to accept educational opportunities. It is the primary goal of PMI to help provide such opportunities.

THE MIST PROGRAM

MARGARET S. KLAPPER, M.D.

The MIST Program is Part I of a larger program to improve physician communication and continuing education between practitioners of Alabama and the School of Medicine. The concept might be said to have arisen from concern by the medical school for: (1) the frequency with which practicing physicians called the Medical Center; (2) the pleas of practicing physicians for help in identifying and reaching appropriate individuals at the Medical Center; (3) expressed needs from practitioners for the reassurance and advice of other physicians through "talking over my patients"; and (4) interest on the part of the Division of Continuing Medical Education for educational programs which would relate learning directly to patient care.

Planning Phase:

During the first six months of 1969 a program was planned and the first steps for implementation were laid by a small committee from the Division of Continuing Medical Education and the Alabama Regional Medical Program. It was the opinion of the planning group that a telephone consultation service, Medical Information Service via Telephone (MIST), was a feasible approach to continuing education but that its success would depend upon its enthusiastic reception by both faculty of the School of Medicine and practicing physicians.

The intent of those concerned was to devise a telephone system that would (1) enhance patient care; (2) bring the practitioner into a closer working relationship with the Faculty of the University of Alabama in Birmingham Medical Center; (3) continue the medical education of the practitioner by aiding him at a time when he needs help with a particular patient problem; (4) reinforce this assistance with pertinent library material; (5) alert the faculty to the changing needs of the community physician; (6) continue the medical education of the academician by providing him a better concept of medical practice and the delivery of medical care, and (7) provide direction to the Division of Continuing Medical Education in identifying educational needs of the physicians of the state.

Provision of an immediate person to person consultative service between practitioners of Alabama and the Faculty of the University of Alabama School of Medicine was the plan devised, with the primary purpose of MIST being improved patient care.

At this point it might be well to point out some of the characteristics of Alabama per se. Alabama is a state of somewhat over 3.5 million people, a total of approximately 2,900 licensed physicians, 2,200 in private practice. The remainder are comprised of full-time faculty, various types of trainees, other full-time employed, and retired or nonpracticing physicians. There is one Medical

School which is part of a state university, and the Alabama Regional Medical Program encompasses the state geographically. Alabama is a rural state with only four cities exceeding a population of 100,000. The physician population is concentrated in these areas resulting in a very low physician:population ratio in rural counties, as demonstrated in Figure 1.

Step 1: Medical Center

The first definitive step by the planning group consisted of individual discussions between department chairmen, divisional directors, and other faculty members of clinical departments, and other areas of the medical center to:

1. Disseminate the basic plan information
2. Assess and stimulate interest
3. Gather specific information for participation

The departments of medicine and surgery and the University Hospital pharmacy and dietetics departments expressed both interest and readiness to participate in such a program immediately. Others were interested but unsure as to their role of participation, largely because of their smaller staff size.

Step 2: Medical Association of the State of Alabama (MASA)

As soon as faculty participation seemed assured, the next step which might be called the "Practitioner Phase" was begun. Members of the planning group personally presented this possibility of a telephone consultative service to the Board of Trustees and Board of Censors of the Medical Association of the State of Alabama and received their approval to proceed.

The Pilot Plan:

The operational pattern, as initially devised, provided for a pilot study in four counties comprised of 300,000 people and 200 physicians. The selection included a rural county (Crenshaw - population 14,690), an urban county (Madison - population 194,360) and two intermediate sized counties (Lee - population 56,069 and Dallas - population 58,491).

By means of a two access state-wide WATS line (in and out) and centrex tie line immediate person-to-person consultation was to be made possible 24 hours a day. A knowledgeable operator would be on duty five days per week and a structured oncall system maintained for medicine and surgery and electronic alerting devices utilized. Practitioners were to be requested to limit night and weekend calls to emergencies and these were to be channeled appropriately by the switchboard operator. All calls were to be recorded and monitored for data gathering purposes.

The specific plan was then presented, personally, by the planning group to the Board of Censors and Board of Trustees of the Medical Association of the State of Alabama and to the four County Medical

Societies. After receiving appropriate approval from these bodies a letter was sent to each physician in the four counties describing the MIST service and inviting him to participate and providing a starting date. A description of the service was also included in the _Journal of the Medical Association of the State of Alabama_ and a news item with the MIST number included in the _Alabama M.D._ Since the WATS line is inclusive of the state, physicians of the entire state were informed through these later publications that they also might use the service.

Funding:

Funding for the six months pilot project was shared by the School of Medicine, partly from AMA-ERF funds and the Alabama Regional Medical Program. Faculty time was provided without reimbursement.

Areas of Concern:

The planning group felt some concern for the following: (1) would this be interpreted as a method to increase referrals to the Medical Center? (2) would practicing specialists consider their consultative services in jeopardy? (3) would enthusiasm of the faculty wane? (4) would other than practitioners and health personnel learn the number and seek information? (5) would practitioners object to identifying themselves and object to the recording? (6) would practitioners and faculty abuse the service? These doubts have all proved unfounded and were quickly dispelled.

Results:

During the first month of operation there were 81 calls from 21 counties. Nineteen of these from 15 doctors within the four counties engaged in the pilot project. These were mailed cards to be returned stating their satisfaction. All were returned and all were complimentary to the Program. By the end of the six month trial period, it was apparent that the whole state was participating in the program as actively as the four pilot counties and results could be studied and tabulated on a state-wide basis. This was also true for the Medical Center. Initially the Departments of Medicine and Surgery were to participate, other departments to be brought into the program later. From the outset, calls to all specialties were received, as well as calls from and to other health personnel. These have all been accepted and channeled as responsively as possible. Hence, what was to be a pilot program from two School of Medicine departments in four counties practically over-night became a Medical Center - State-wide program. Two-thirds of 125 evaluation cards to physicians at the end of the six months period were returned. All expressed approval and some offered constructive criticism and suggestions.

Utilization of the service is best shown through the tabulations and graphs. The monthly utilization of incoming calls is shown in Figure 2 and the curves of utilization by specialists, general practitioners and other health personnel in Figure 3. General practitioners in Alabama constitute a little more than 30% of the physician population exclusive of full-time faculty physicians. The Department of Medicine receives by far the greatest number of calls as demonstrated in Figure 4, and the breakdown by divisions is depicted in Figure 5. Figure 6 is a map depicting practitioner calls geographically and the number of calls per physician caller in Table 1. Table 2 tabulates the number of calls per faculty responder and the total number of faculty who have participated during the first year of operation. The academic rank of faculty responders is demonstrated in Figure 7. To date, 4,473 pages of library material have been sent as followup material to consultations or upon the physician's request.

The pattern which emerges shows(1) most calls are directly related to individual patients, usually while the patient is in the practitioner's office, (2) few are emergencies of great immediacy and practitioners cooperate in limiting night and weekend calls to emergency situations, (3) most inquiries are about new and advanced forms of therapy to be used there and then for patients or about new and advanced diagnostic techniques, (4) many patients discussions require ongoing telephone discussions over a period of hours, days, and sometimes weeks and the number of outgoing calls exceeds the number of incoming calls.

By the end of nine months, utilization of the service had exceeded the capabilities of the system and it was necessary to add additional equipment and personnel. The system has shown a surprising ability to grow and accommodate to an increasingly wide range of problems and no area in the Medical Center has refused to cooperate in the program.

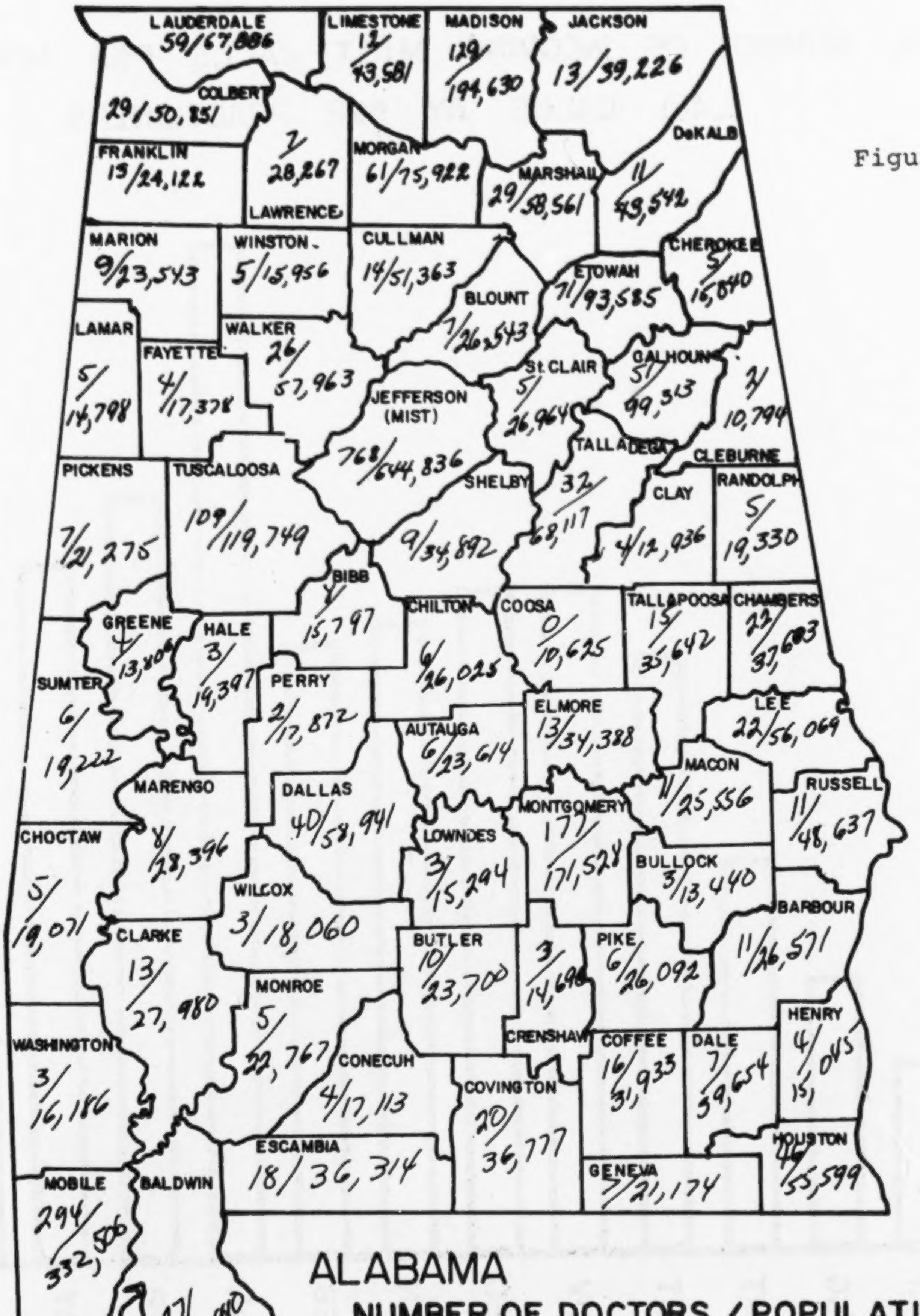
The only real problem to the Medical School has been the cost. The essentials for operation during the first six months, exclusive of all but equipment, operator salary, phone and rental was approximately $11,000. For the next 12 months these expenses reach $32,000. This figure becomes considerably greater if administrative and office costs were to be included, and would be multiplied many times if faculty participation estimates were included.

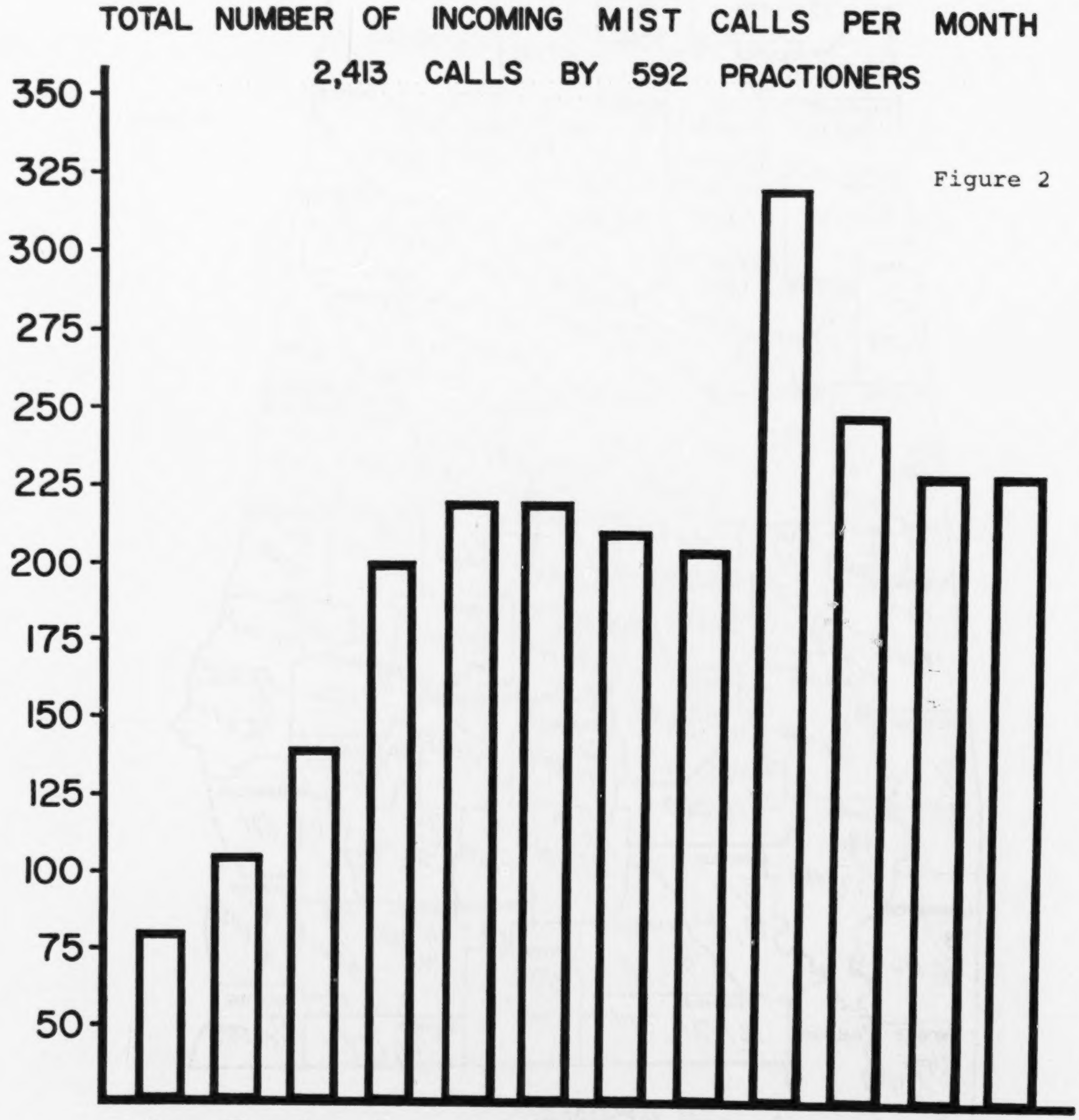
Conclusion:

Experience of one year with the MIST program indicates that it is a practical method to serve as a consultative device between practitioners and faculty of the Medical Center. The objectives are being met and patient care is being improved. The major disadvantage at the present time is the cost and uncertainty of the source of financial support for its continuation and its expanding role.

Figure 1

MIST SERVICE JULY 1, 1969—JUNE 30, 1970

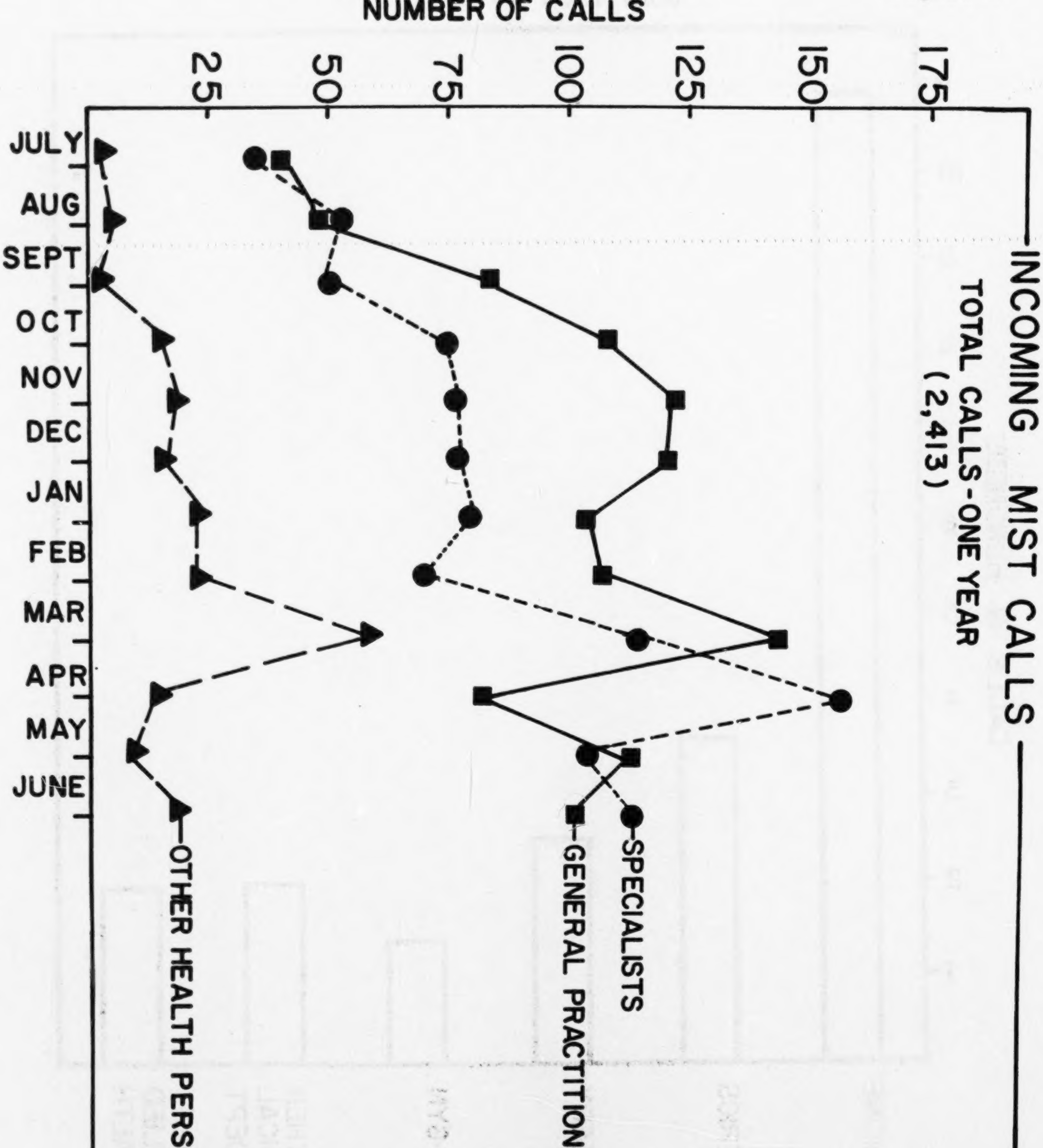




TOTAL NUMBER OF INCOMING MIST CALLS PER MONTH
2,413 CALLS BY 592 PRACTIONERS

Figure 2

Figure 3


INCOMING MIST CALLS
TOTAL CALLS-ONE YEAR
(2,413)
NUMBER OF CALLS
175
150
125
100
75
50
25
JULY
AUG
SEPT
OCT
NOV
DEC
JAN
FEB
MAR
APR
MAY
JUNE
SPECIALISTS
GENERAL PRACTITIONERS
OTHER HEALTH PERSONNEL

NUMBER OF CALLS RECEIVED BY DIVISIONS IN MEDICINE
JULY 1969 — JUNE 1970

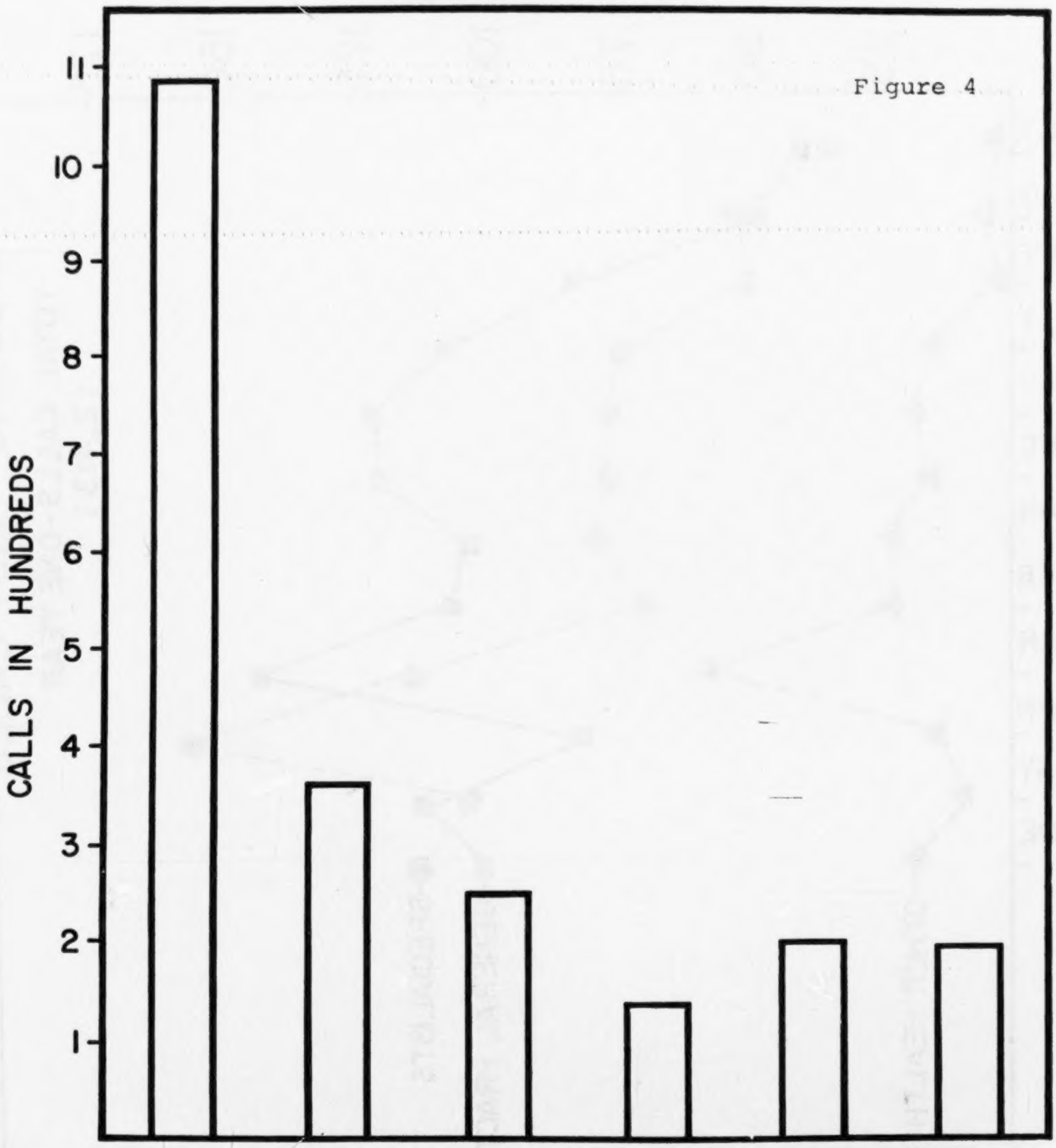
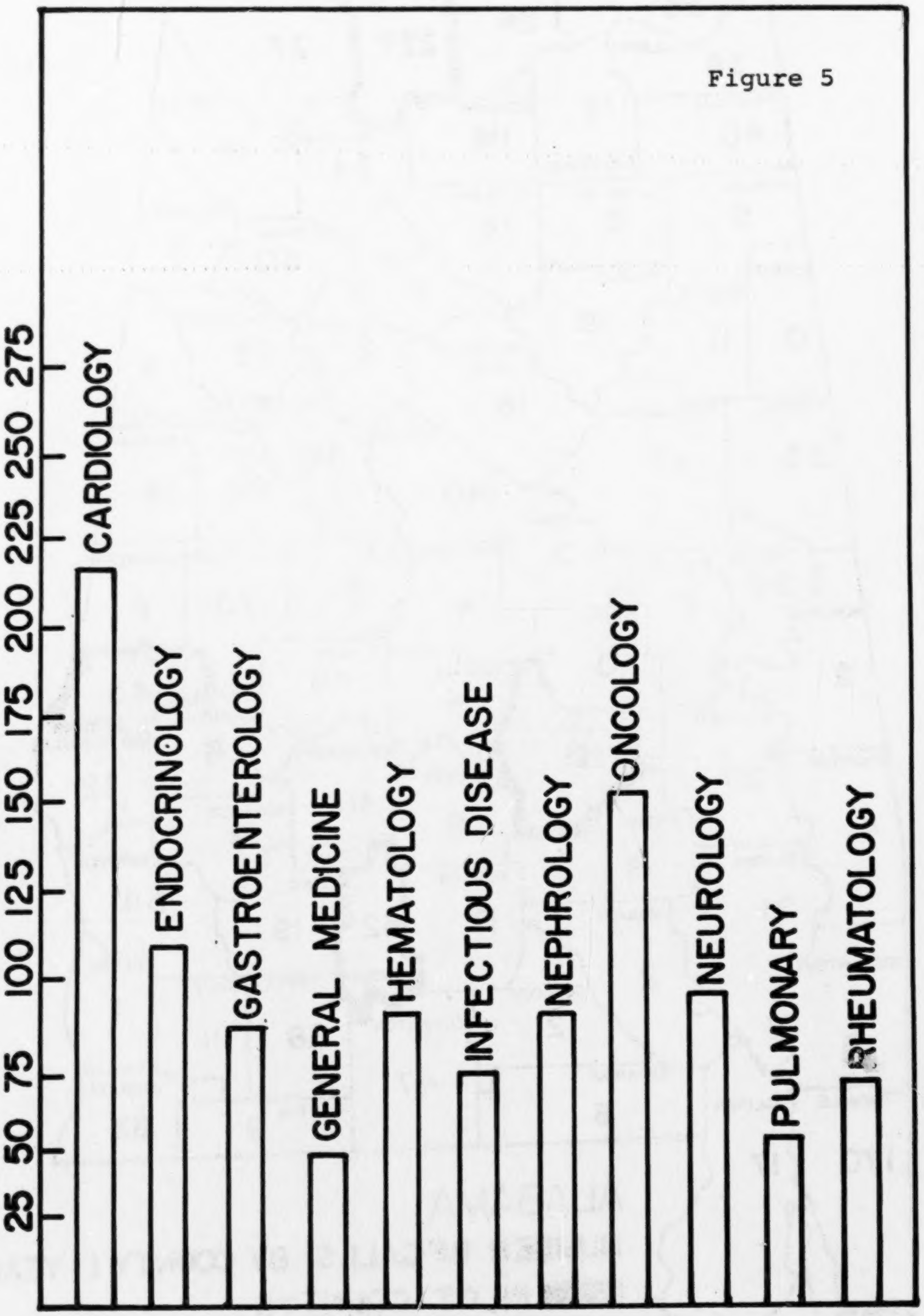


Figure 4

Figure 5

MIST —(FIRST YEAR)

UAB—SCHOOL OF MEDICINE



NUMBER OF CALLS RECEIVED BY DIVISIONS IN MEDICINE

JULY 1969— JUNE 1970

MIST SERVICE JULY 1, 1969—JUNE 30, 1970

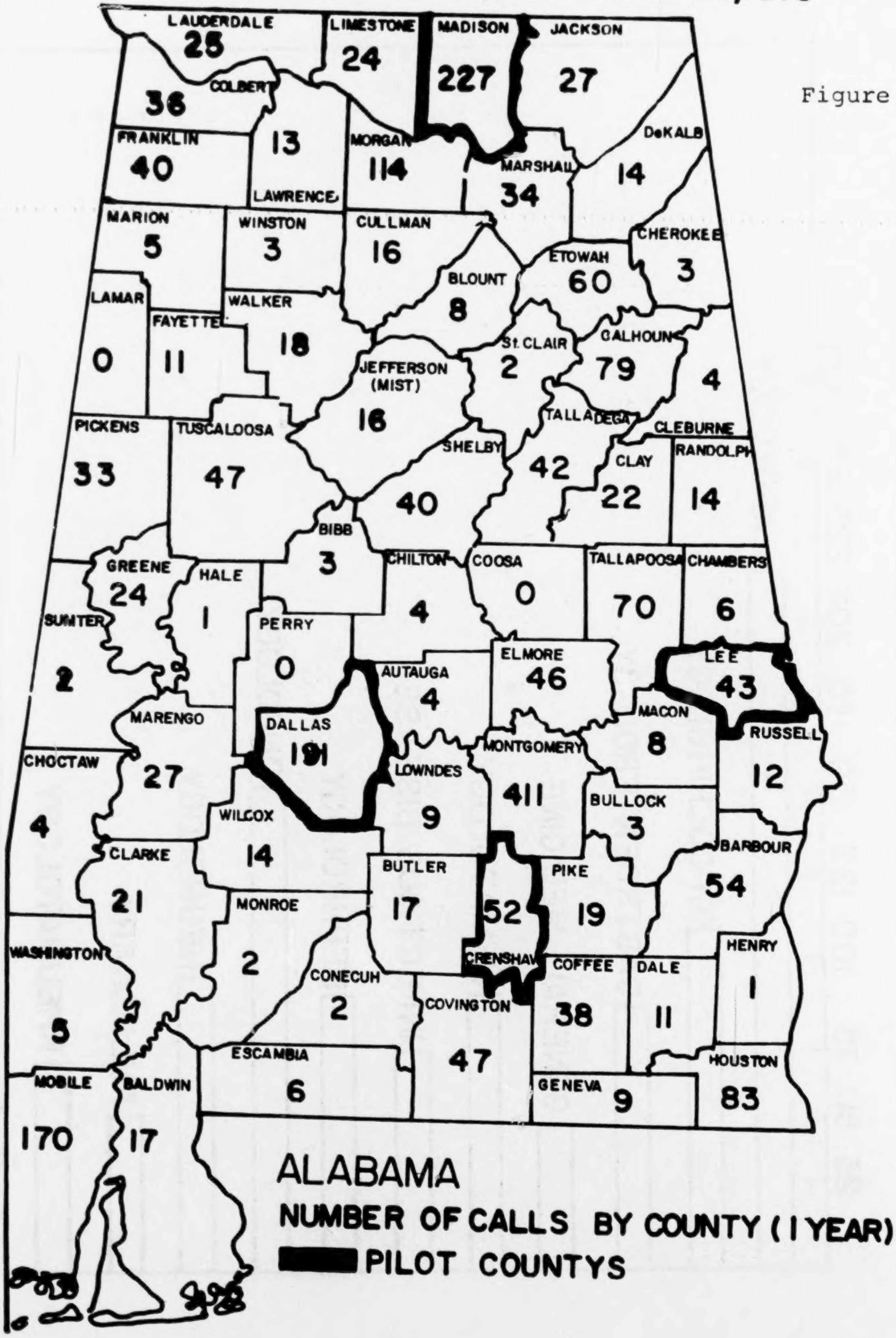


Figure 6

Figure 7

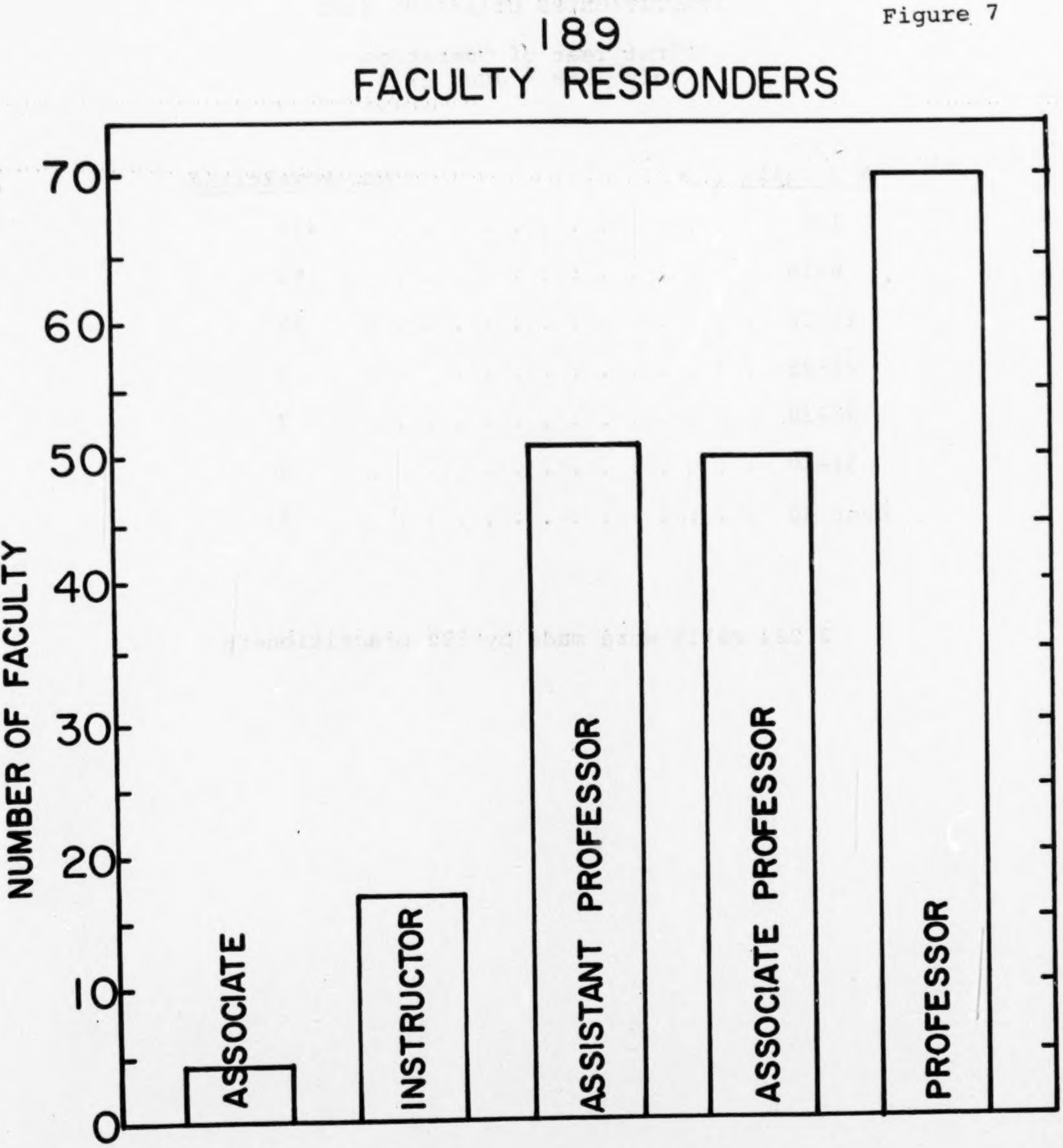

189
FACULTY RESPONDERS
NUMBER OF FACULTY
70
60
50
40
30
20
10
0
ASSOCIATE
INSTRUCTOR
ASSISTANT PROFESSOR
ASSOCIATE PROFESSOR
PROFESSOR

TABLE 1

PRACTITIONERS UTILIZING MIST

First Year of Operation
July 1969 - June 1970

No. Calls	No. Physicians
1-5	436
6-10	61
11-20	32
21-25	4
26-30	3
31-40	6
Over 40	2

2,224 calls were made by 592 practitioners

TABLE 2

FACULTY RESPONDING TO MIST CALLS

First Year of Operation
July 1969 - June 1970

No. Calls	No. Faculty
1-10	125
11-20	25
21-30	19
31-40	2
41-50	2
51-60	2
61-70	0
71-80	0
81-90	0
91-100	1
Over 100	1

1,723 calls were responded to by 177 faculty

CLINICAL TRAINEESHIPS

E. T. LISANSKY, M.D.

The implementation of this program at the University of Maryland School of Medicine was stimulated by an article written by Robert McFarland of Boulder, Colorado, for the "Pharos of Alpha Omega Alpha" in July, 1964. A paraphrase of what he wrote is as follows:

> "Postgraduate education must be tailored to meet the need of the physician-students. One way to help the postgraduate student study what he feels is important, and at the same time, expose him to what others feel is important is to allow him to partake and join, for any reasonable length of time, the traditional residency training programs in teaching hospitals." He continued, "Most doctors would feel that one to four weeks a year in a refresher residency would give them much of what they want in terms of continuing education."

In February of 1965 the plan to develop an "In-Service Traineeship" was discussed by the Committee on Continuing Medical Education and it was unanimously agreed that this could be a significant and meaningful extension of the more formal, traditional postgraduate courses, and that this "Visiting Traineeship" should be added to the on-going established curriculum of continuing medical education. It was suggested that the Director of Continuing Medical Education write an explanatory letter of this tentative program to every department and division head, including those of the basic science departments. Every department and division head answered affirmatively and each, as requested, appended a weekly schedule of the undergraduate (medical school) and postgraduate (residency and staff) conferences of his particular department or division. The schedules of individual departmental and divisional conferences, rounds, etc., were gathered anew by the office of Continuing Medical Education, each summer, to correct for any curriculum changes in time, place, etc.

In March of 1965 this plan was presented to an unanimously approved by the Faculty Board of the Medical School. An informative letter was written to the Intern-Resident Staff to acquaint them with this program and request their compliance, courtesy and cooperation. (This must be done anew each year after July 1st.) The Health Sciences Library personnel and the Director of the University of Maryland Hospital were informed of this program in order to solicit their approval and cooperation.

The following is an abbreviated outline of the program:

1. Each year an explanatory brochure with a detachable application questionnaire was sent to every physician in the state of Maryland.

2. This program was listed annually in the issue of the *JAMA* publicizing postgraduate activities.

3. Each year the *Maryland State Medical Journal* and the University of Maryland School of Medicine *BULLETIN* published a full-page information sheet covering the program.

4. The charge for each trainee was established as $10 per day. The minimum enrollment time was set at one week - namely five days, Monday through Friday.

5. After the application was received and the trainee tentatively accepted, he either visited or talked by phone with the specific department or division head concerned to clarify the schedule, appropriateness as to the timing of his visit, etc. These faculty members already had received a copy of all correspondence and the application blank previously sent to the office of Continuing Medical Education by the applicant. If geographical distance made a preliminary visit inconvenient, the applicant was advised to correspond directly with the department or division head so that both he and the faculty-host were assured of agreement.

   Copies of all correspondence concerning every applicant were shared by the department head, the office of Continuing Medical Education and the applicant so that sources of error and misunderstanding were minimized.

6. The trainee was the "guest" of the head of a specific department or division of his choice. He was invited to participate, as actively as his own impetus allowed, in the routine schedule of rounds, clinics, conferences and lectures. He took histories, examined patients and participated in discussions concerning the decisions of diagnosis and management. His involvement and work did not replace the responsibility of the attending and house staffs for the official work-up and the written orders on the chart.

7. Each applicant's curriculum schedule was individually designed and kept flexible; however, no alteration in the departmental routine was made to formalize this program into a specific postgraduate course. Allowances were made for cross-disciplinary visiting (for example, combining both rheumatology and cardiology or cardiology and bacteriology) where there was little conflict in the schedule of seminars, rounds, etc. In most instances, however, the trainee was immersed for one or more weeks, in the work of one specific division, subject or medical problem.

8. Although the minimum enrollment was for one week (five

days), longer periods of traineeship were arranged for over 20% of the enrollees since the program began four and one-half years ago. (See Figure 1). These special arrangements were made with the approval of the office of Continuing Medical Education and the head or heads of the Departments or Divisions who would be host to the enrollee. Occasionally a trainee stayed for two to four weeks and divided his time between two to four departments or divisions.

9. Ample allowance of time was made for collateral reading in the privacy of the Health Sciences Library where the enrollee was assigned a private cubicle.

10. The enrollee was informed of and cordially invited to attend all guest lectureships, grand rounds and special professional meetings where it was appropriate and where he had an interest. He was informed of other medical meetings, lectures and seminars in other institutions in the city, away from the University Medical Campus where he might be interested in attending. (Evening professional meetings of the Baltimore City Medical Society and the Maryland State Medical Society.)

11. This program rarely accepted visits from trainees during the months of June, July and August, except by special arrangement with a department head because the medical school program of education, faculty presence, and house staff experience is abridged during these summer months.

12. Thus, various departments, divisions and subdivisions of the University of Maryland School of Medicine and University Hospital were open to interested physicians through a "Visiting Traineeship In-Service Program" designed to expose the practicing physician to current concepts in the practice of medicine, surgery, pediatrics, psychiatry and their various subspecialties.

13. We hope this program offered a wide variety of possibilities that allowed a profitable and rewarding learning experience.

Certain points of information with reference to the host-faculty are as follows:

1. No division of the various medical school departments was expected to accommodate more than one visiting trainee at a time. Each division was not expected to have more than five enrollees during a specific scholastic year; however, this depended on the number of weeks each applicant stayed in any one division and how willing and able this particular division was to meet with an excessive application request. (See Figure 3 - Cardiology).

2. The Chairman of the Committee on Continuing Medical Education assumed the responsibility of arranging any special traineeships in local affiliated hospitals or facilities when this learning experience was not available at the University Hospital. (Such as (1) Industrial-Occupational Medicine, (2) Geriatrics and (3) Rehabilitative Medicine in Chronic Disease).

3. It was the responsibility of the Chairman of the Committee on Continuing Medical Education and his executive secretary to be available and responsive to the needs of the visiting trainee, arranging for appropriate hospitality, hotel rooms, etc. If possible, and when appropriate, the Chairman of the Committee on Continuing Medical Education spent some time in cordial, social engagement with the trainee. This allowed for immediate feedback from the trainee and a correction of any problems that may have developed in the implementation of the program.

4. It was found that an attitude of cordial receptivity by the division head and a corresponding attitude by his chief resident or fellow was the most important ingredient in the success of this program. We have been very fortunate in this regard since our faculty values teaching, learning, and continuing medical education.

Four slides will be shown of the following enclosures:

1. Figure 1
2. Figure 2
3. Figure 3
4. Figure 4

POSTGRADUATE IN-SERVICE TRAINEESHIP

Univ. of Md. School of Medicine
1966-1970

Total attendance	46
Maryland Graduates	11 (1 repeated)
Maryland Residents	23
Out of state residents	23 (22 cities, 15 states, including Hawaii & Argentina)

Length of Traineeship:

One week	36	physicians
Two weeks	3	"
Four weeks	5	"
Four months	1	"
1 afternoon per week for 9 months	1	"
	46	= 89 weeks of In-service training

Fig. I

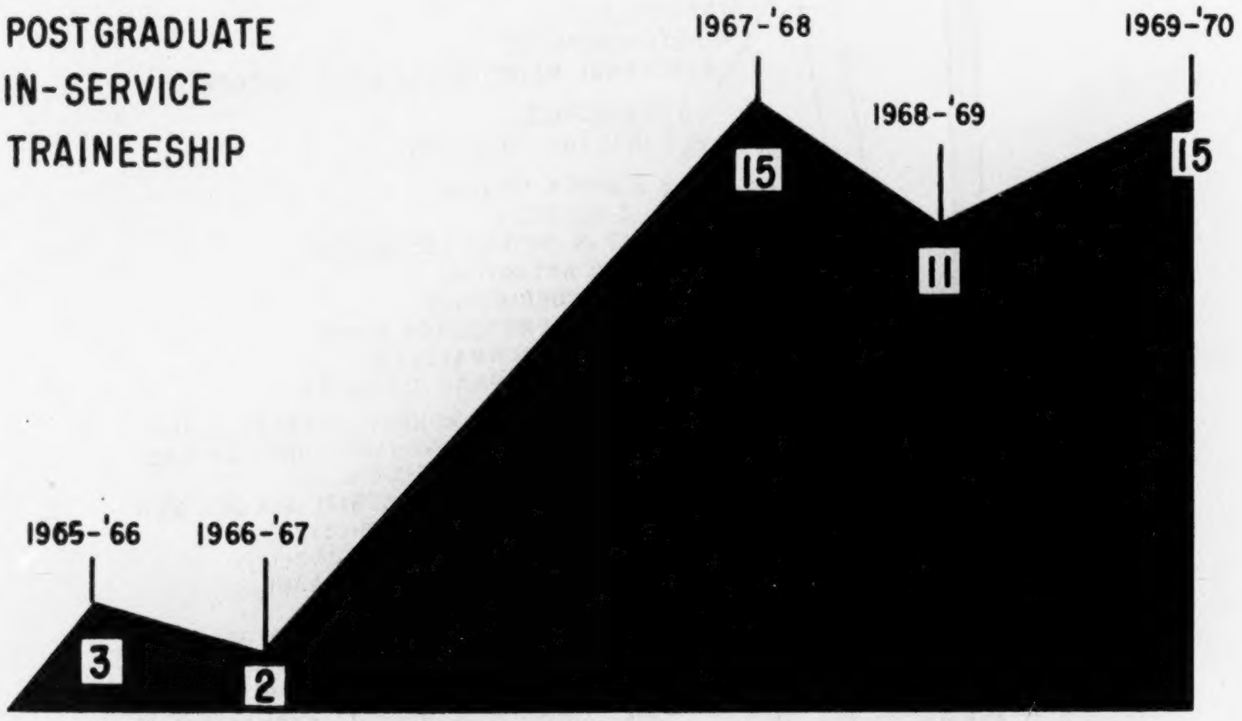

POSTGRADUATE
IN-SERVICE
TRAINEESHIP
1965-'66
3
1966-'67
2
1967-'68
15
1968-'69
11
1969-'70
15

Fig. 2

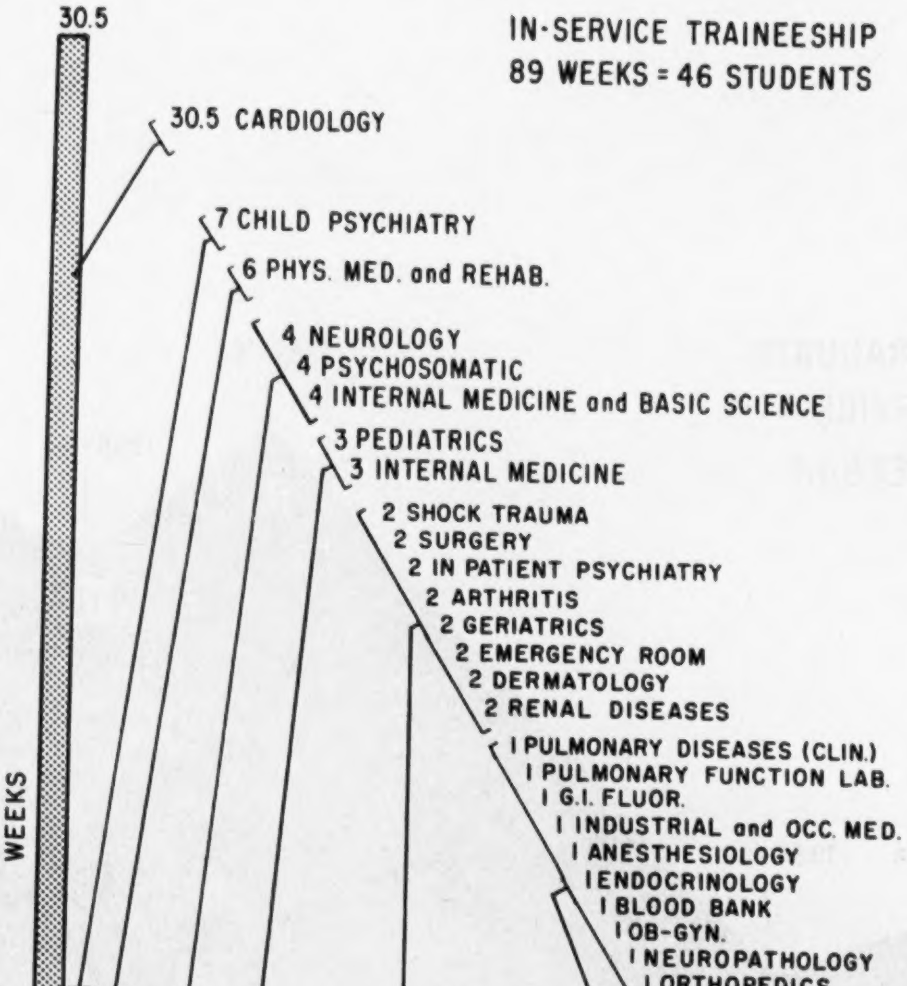

IN-SERVICE TRAINEESHIP
89 WEEKS = 46 STUDENTS
WEEKS
30.5
30.5 CARDIOLOGY
7 CHILD PSYCHIATRY
6 PHYS. MED. and REHAB.
4 NEUROLOGY
4 PSYCHOSOMATIC
4 INTERNAL MEDICINE and BASIC SCIENCE
3 PEDIATRICS
3 INTERNAL MEDICINE
2 SHOCK TRAUMA
2 SURGERY
2 IN PATIENT PSYCHIATRY
2 ARTHRITIS
2 GERIATRICS
2 EMERGENCY ROOM
2 DERMATOLOGY
2 RENAL DISEASES
1 PULMONARY DISEASES (CLIN.)
1 PULMONARY FUNCTION LAB.
1 G.I. FLUOR.
1 INDUSTRIAL and OCC. MED.
1 ANESTHESIOLOGY
1 ENDOCRINOLOGY
1 BLOOD BANK
1 OB-GYN.
1 NEUROPATHOLOGY
1 ORTHOPEDICS
1 CLINICAL LAB.
½ BACTERIOLOGY
7
6
4 4 4
3 3
2 2 2 2 2 2 2 2
1 1 1 1 1 1 1 1 1 1 1
½

Fig. 3

IN SERVICE PROGRAM: STATISTICS

ALL STUDENTS SPENT FULL TRAINING PERIOD IN ONE AREA ONLY

EXCEPT

1 STUDENT: 2/3 WEEK IN CARDIOLOGY
1/3 WEEK IN BACTERIOLOGY (THROAT CULTURES)
1 WEEK TOTAL

1 STUDENT: 1 WEEK IN EMERGENCY ROOM
1 WEEK IN IN-PATIENT AND OUT-PATIENT SERVICE
2 WEEKS IN OB.-GYN.
1 MONTH TOTAL

1 STUDENT: 4 WEEKS TRAINING IN GENERAL MEDICINE COVERING MANY DEPARTMENTS INCLUDING BASIC SCIENCE
1 MONTH TOTAL

1 STUDENT: 1 WEEK IN NEUROLOGY
1 WEEK IN NEUROPATHOLOGY
2 WEEKS TOTAL

1 STUDENT: 2 WEEKS IN CARDIOLOGY
2 WEEKS IN RENAL DISEASE
1 MONTH TOTAL

Fig. 4

THE PHYSICIAN PROFILE PROGRAM FOR CONTINUING MEDICAL EDUCATION

S. E. SIVERTSON, M.D.

Have you ever heard of an educational consultant to a private practicing physician? During 15 years of private practice I hadn't but after joining the faculty of the Medical School at Wisconsin I did. Meeting there with a team of co-workers and mutually considering the role of an educational consultant, some basic questions and premises led to the design of an intriguing experiment.

1. DO MEDICAL EDUCATORS REALLY KNOW WHAT A PRACTITIONER's NEEDS ARE?

A presumptive answer was that they did not - it was rare indeed that at Wisconsin a faculty member had ever been in competitive private practice. Then too, investigation and searching conversations for expertise on this point led to dead ends.

2. DO PRACTITIONERS KNOW THEIR OWN NEEDS?

Recent self examination (designed by the American College of Physicians) did much to assess physician needs in terms of biological factual knowledge. Relating that to needs in a physician's practice however was a dimension left wanting. Then too, what a practitioner thinks his needs are and what they really are may be widely divergent.

3. HOW DOES ONE FIND OUT A PRACTITIONER'S NEEDS?

To answer this took us to the practitioner. Joined with him the union became a cooperative adventure called the Individual Physician Profile (I.P.P.).*

4. HAVING FOUND OUT, WHAT CAN BE DONE ABOUT IT?

The search for answers here seemed insurmountable yet perseverance and dedication by many individuals - most importantly the practitioners themselves - strongly suggested a consultation resource was desirable.

Figure 1 shows the basic design of I.P.P. which comprised three parts. Slowly data was gathered about the problems patients brought to their private physicians, PRACTICE PROFILE, and in addition uncovered significant management problems a practitioner was forced to cope with. Based on the practice profile an EXAMINATION was designed to assess the practitioner's knowledge pertinent to his patients' problems. Armed then with a practice profile and results of an examination, a faculty member, CONSULTANT, met with the practitioner and designed a continuing educational program tailor made to the practitioner's needs. Projecting into the future we could dimly envisage a given practitioner's profile changing with the years - he could then refer himself back for periodic re-evaluation and consultation.

---

* Funded through the Bureau of Health Professions Education and Manpower Training, National Institute of Health #70-4030.

In the beginning, practicing physicians were invited to participate. Thirty-seven accepted and took part during the project's first year. Of these, 28 were in General or Family Practice, four in Internal Medicine, four in Pediatrics and one in Surgery.

PRACTICE PROFILE - HOW IT WAS OBTAINED

A medical secretary was trained to help a physician analyze his practice. She literally walked at his heels for one week and obtained information about every patient contact in his office, in the hospital, on the telephone and in the patient's home. In addition to the patient's age, sex and type of contact, she recorded, on a work sheet, the presenting symptoms, positive physical findings, the physician's working diagnosis, diagnostic tests ordered and treatment prescribed.

The working diagnosis, as ultimately recorded, fit the International Classification of Disease, amounting to 18 different categories. From this a profile was generated based on the percentage of patient problems seen in each category during the period of one week.

The profile made possible a realistic examination, in that it tested the physician on what he saw in his practice. Obtaining enough questions for testing was one problem, obtaining relevant questions was quite another matter, as we shall see.

GENERATION OF A TEST BANK

Examination questions were collected from a variety of sources, months in advance, and totaled about 1,800. A vast majority of them were of the four or five option multiple choice type.

The questions were then classified into 18 categories corresponding with the International Classification of Disease. In addition, each question was given a level of sophistication based on the following broad criteria:

Level I - A common clinical situation, an "on the spot" decision.
Level II - A decision requiring commonly available diagnostic tools and procedures.
Level III- A problem or technique requiring special knowledge or training.

The questions were then stored in a Burroughs B 5500 computer under specific diagnostic categories and degrees of sophistication as noted above.

PHYSICIAN AND EXAMINATION MEET

Preliminary trials revealed that about 100 questions required two hours for a practitioner to answer. Such a test was administered in the physician's office or home via teletype to the computer question bank in Madison. The physician took this examination in the afternoon on the last day of the week.

The examinee punched the teletype key indicating his choice of answer. This brought an immediate response from the computer to the teletype indicating whether the choice was correct or wrong and if wrong the correct answer followed. At the conclusion he received a summary of the results which he retained along with the teletype print out of the examination.

The test was devised by formula derived from the practice profile. It was not feasible to test in all 18 categories of the International Classification within the two hour limit; therefore, the test was restricted to four or six of the categories making up the greatest percentage of the practice profile. A minimum of 11 and maximum of 36 questions was set for each selected category.

Since each practitioner's patient problems differed and since questions were randomly selected by the computer, all participants were assured that no two tests were identical. This prevented test score comparisons among themselves and with any outside group.

ENTER A CONSULTANT

A practitioner elected to either come to Madison to meet with his consultant or have the consultant travel to him.

Consultation approached the examination first. Questions were reviewed from the standpoint of relevancy to the practice. The practitioner gave an immediate impression (gut reaction) to each question and the consultant recorded it. This introduction usually established rapport and assessed relevancy of the questions.

Figure 2 shows that approximately 30-40% of the questions were judged not pertinent or impertinent (if you prefer) - a sad commentary on the questions and opened an appalling problem of improving the test bank.

From there, the discussion proceeded to practice problems in general, a historical review of changing cultural and economic patterns in the community that influenced practice and to some understanding about how the practitioner learned best.

Of immediate concern was the handling of phone calls. Some physicians averaged 50 per day and others only ten. Comparison of methods of handling telephone traffic from one practice to another was instructive. Delegation of responsibility to allied personnel led to productive insights.

Finally, if rapport was satisfactory it was possible to ask a practitioner what aspects of his practice gave him greatest anxieties.

At this point let me present two case histories. First is a general practitioner in a metropolitan area, about 40 years of age and in practice approximately ten years. His practice profile is shown on Figure 3 with categories 16 undiagnosed, 7 respiratory, 14 accidents, poisoning and violence and 10 obstetrics predominating. The results of his examination revealed that he was questionably in need of updating in factual knowledge. Relationship between the consultant and his practitioner however, was such that it revealed a part of the practice which was causing him apprehension. This was in obstetrics and the problems attendant to deliveries. Here the consultation part of I.P.P. recognized a need.

The second physician was about 40 years of age from a small community in northern Wisconsin who had been in practice approximately ten years. His practice profile is shown on Figure 4; the four main categories were: 7 respiratory, 10 obstetrics, 14 accidents, poisoning and violence and 4 mental and psychoneurotic. He was obliged to do much emergency work for the territory. Here the results of examination suggested that an increase in factual knowledge pertaining to trauma and other emergencies might be helpful.

The consultant was now challenged. How could he design a program to meet each of these physician's widely differing needs? Much searching was necessary to identify appropriate training programs which would not only add factual knowledge but also develop skills.

For the first physician a two-week on-the-job experience in a very busy delivery room was arranged through the cooperation of the head of the department of obstetrics and gynecology in a private hospital. In the second case, arrangements were made for a two week special program in emergency room care at the Massachusetts General Hospital.

EDUCATIONAL RESOURCE INDEX

Upon completion of the first year of the study it was apparent that the 30 consultants shared a common sense of helplessness and frustration. For example, an internist with special interest in diabetes could not give of his expertise to a practitioner whose needs were Neonatology. His frustration grew as he searched for a suitable program and found the process time consuming and cumbersome. To facilitate consultation a smaller number of consultants seemed advisable and in addition an educational resource index came into being. Its basic principles, as designed in a computer, are shown in Figure 5.

Based on experience with 37 physicians we expanded the 18 major categories in the International Classification of Disease to 54 categories. We wanted to be sure that such common patient problems as obesity and diabetes would be more specifically identified; as it was they appeared to be buried in a broad classification of

Endocrine, Metabolic and Nutritional Diseases constituting category III.

As shown in Figure 5, the example used is category III-1, Diabetes, which for this illustration may be considered a major patient problem in a given physician's practice profile. Examination results suggested a need for updating knowledge in this area. We can now ask the computer for an up-to-date listing of educational programs pertaining to diabetes.

The computer does so by dividing the educational programs into two main categories. The first being those for which he must leave home, i.e., AWAY in either conferences or apprenticeships. The second major category would be those programs he could study at HOME with audio-visuals, programmed instruction, computer assisted instruction, text books and journals.

This resource index is now updated each month. Consequently, the consultant may ask the participant about the time of year he can leave his practice to attend a conference or apprenticeship; the computer, at an appropriate time interval, will print out a list of those conferences scheduled at that time of year along with those for home study. The consultant now has information that is accurate, comprehensive and quickly obtained. It is available to the participant at the time of the consultation or at any time subsequent to it for updating.

CONCLUSION

The process of consulting with a private practicing physician about his educational needs takes on a familiar format. It requires a HISTORY of present and past problems (practice profile) an EXAMINATION to illuminate potential areas for assistance and final CONSULTATION to consider remedial and strengthening measures.

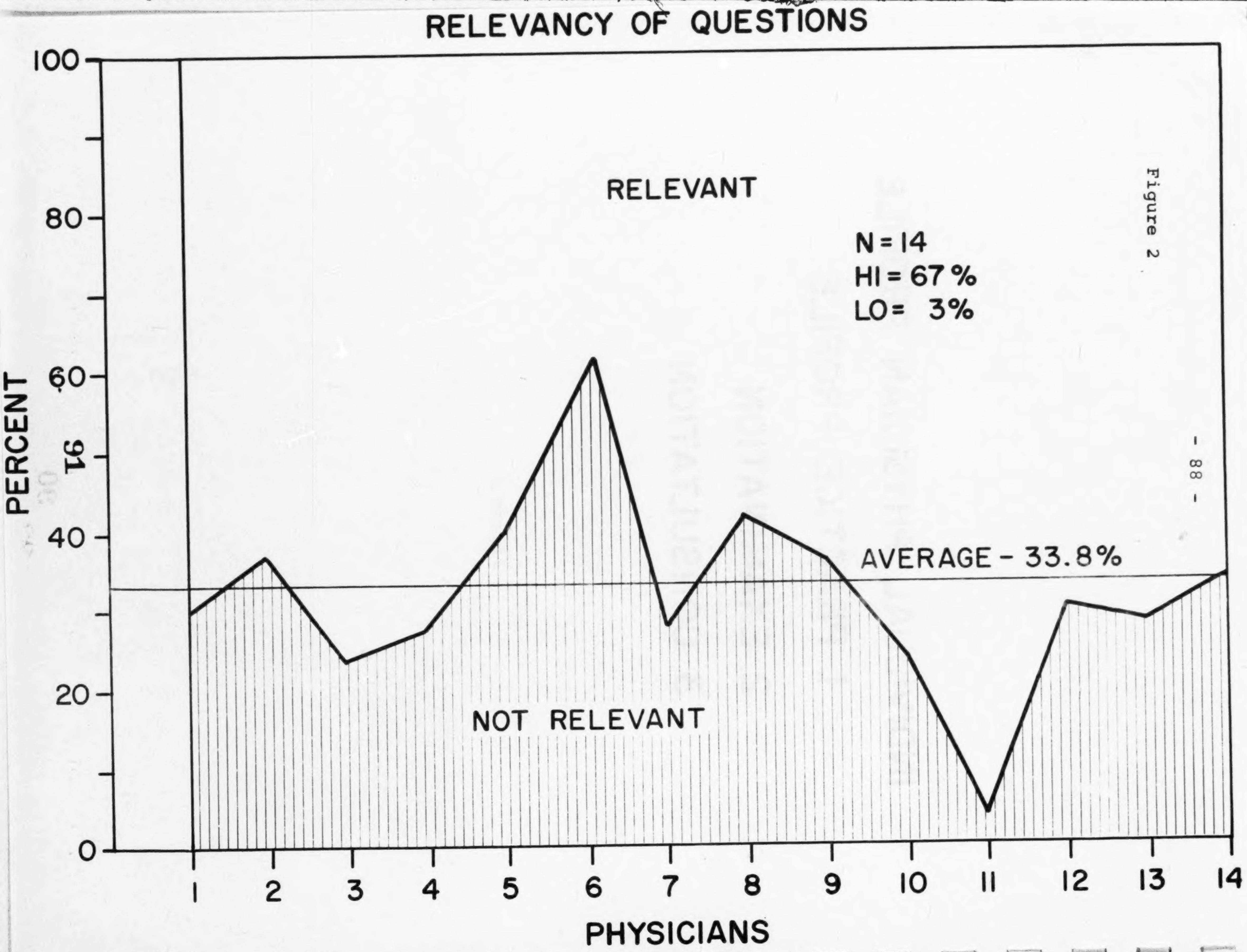
Experience to date has shown that physicians in competitive practice will participate in such a program.

INDIVIDUAL PHYSICIAN PROFILE

1. PRACTICE PROFILE
2. EXAMINATION
3. CONSULTATION

Figure 1

Figure 2



RELEVANCY OF QUESTIONS

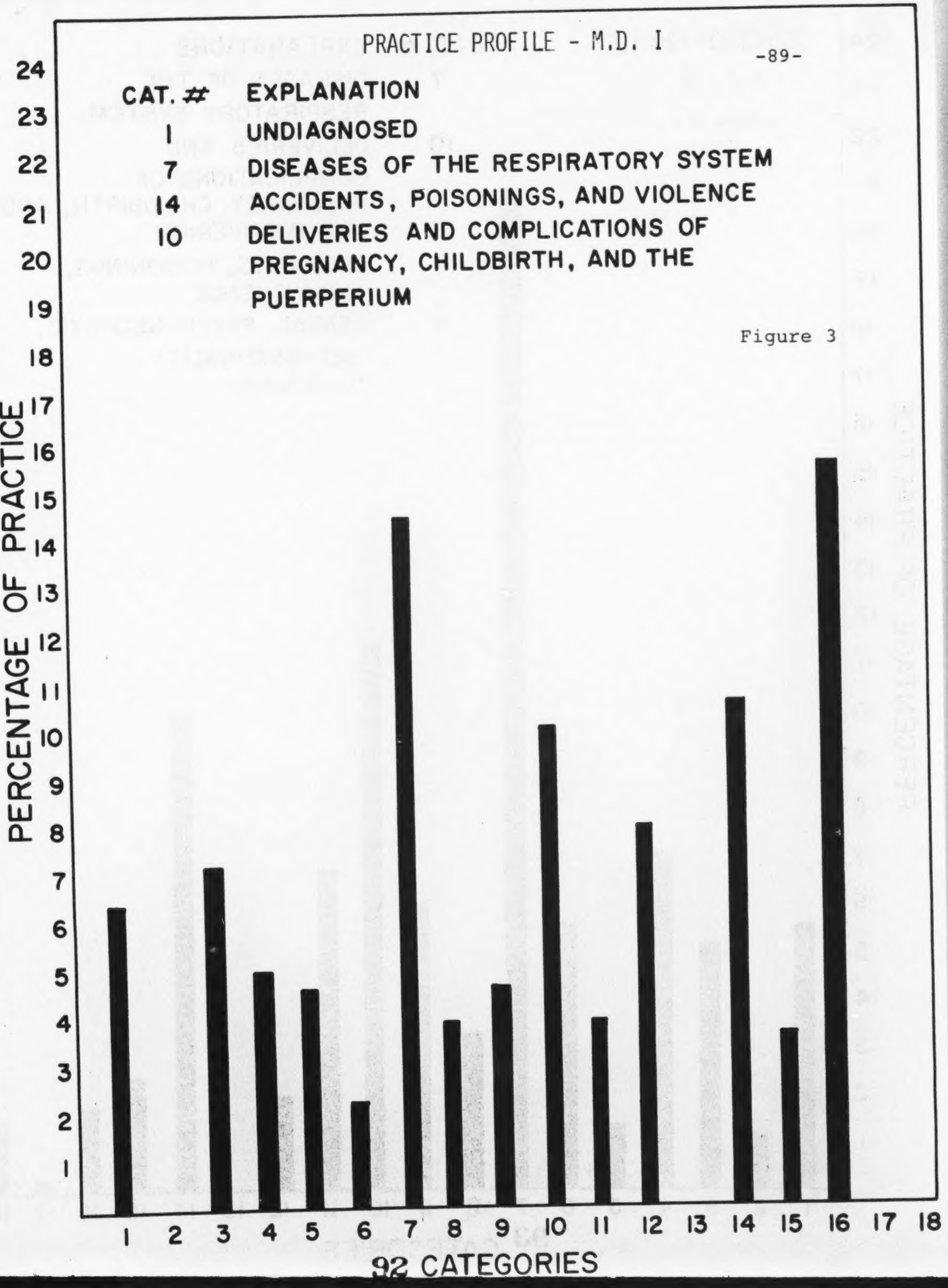
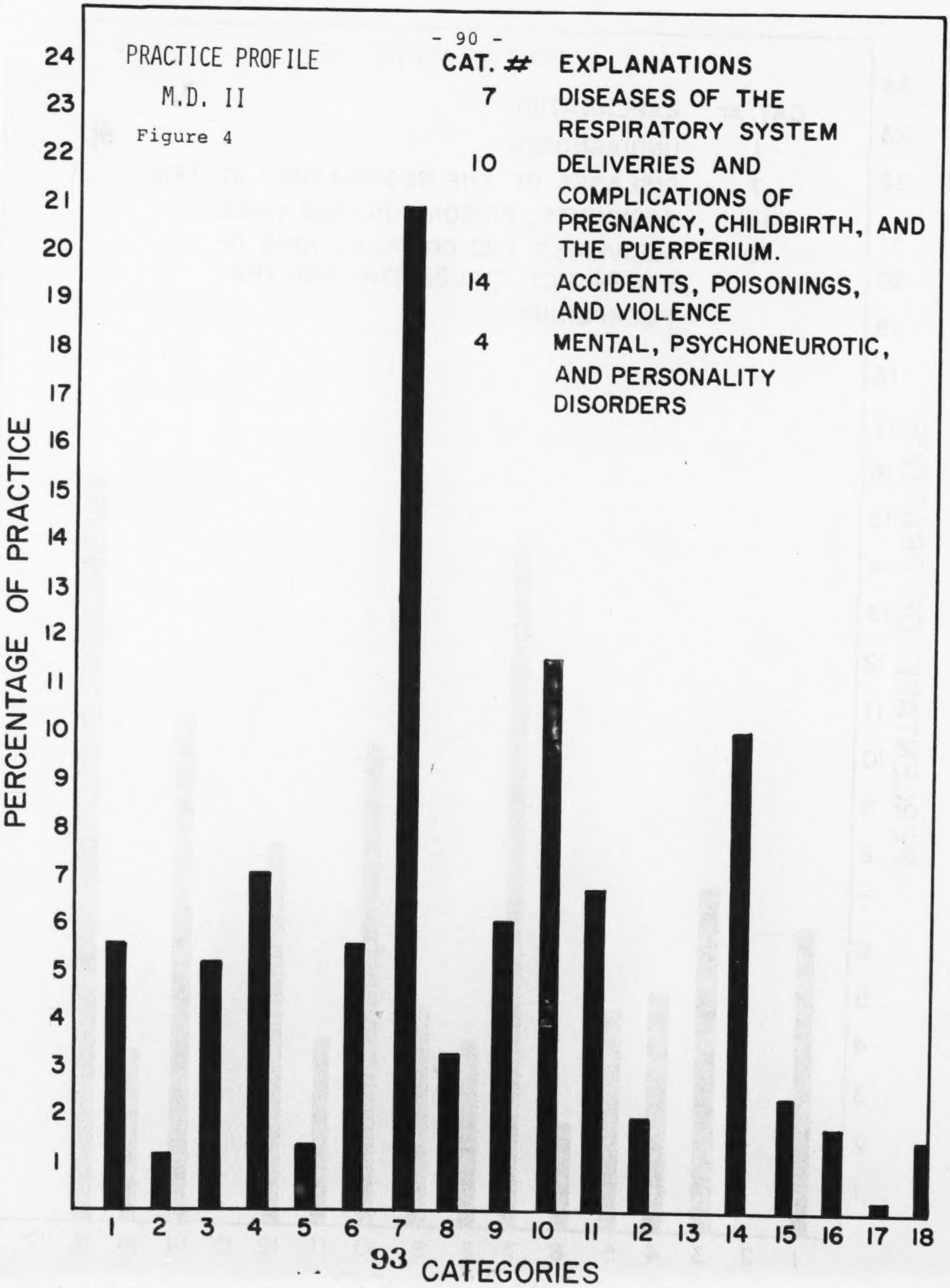

PRACTICE PROFILE - M.D. I
CAT. #
EXPLANATION
1
UNDIAGNOSED
7
DISEASES OF THE RESPIRATORY SYSTEM
14
ACCIDENTS, POISONINGS, AND VIOLENCE
10
DELIVERIES AND COMPLICATIONS OF PREGNANCY, CHILDBIRTH, AND THE PUERPERIUM
PERCENTAGE OF PRACTICE
24
23
22
21
20
19
18
17
16
15
14
13
12
11
10
9
8
7
6
5
4
3
2
1
1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
92 CATEGORIES

Figure 3



PRACTICE PROFILE

M.D. II

Figure 4

CAT. #	EXPLANATIONS
7	DISEASES OF THE RESPIRATORY SYSTEM
10	DELIVERIES AND COMPLICATIONS OF PREGNANCY, CHILDBIRTH, AND THE PUERPERIUM.
14	ACCIDENTS, POISONINGS, AND VIOLENCE
4	MENTAL, PSYCHONEUROTIC, AND PERSONALITY DISORDERS

EDUCATIONAL RESOURCE INDEX

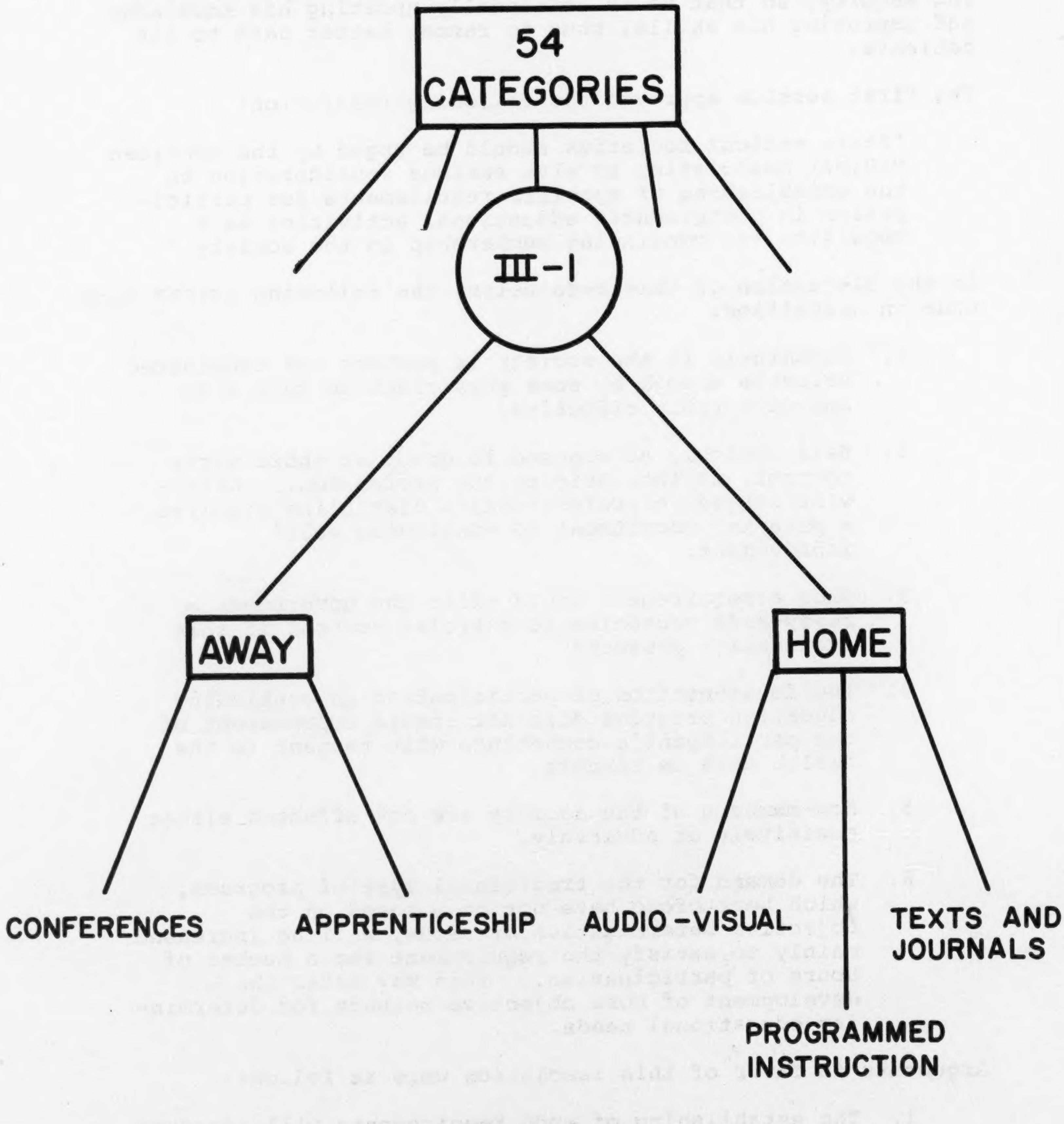


Figure 5

WORKSHOP ON MOTIVATION

We concerned ourselves with those forces which, from within or without, influence the physician to use the process of continuing enquiry, so that he is continually updating his knowledge and improving his skills, thus to render better care to his patients.

The first session approved the following resolution:

> "State medical societies should be urged by the American Medical Association to give serious consideration to the establishing of specific requirements for participation in postgraduate educational activities as a requisite for continuing membership in the society."

In the discussion of this resolution, the following points were made in opposition:

1. Membership in the society is perhaps not considered valuable enough by some physicians to make this approach truly effective.

2. Self-control, as opposed to group or third party control, is intrinsic to the profession. Otherwise stated, a professional's discipline requires a personal commitment to continuing self-improvement.

3. Such a requirement would offer the government a ready-made mechanism to exercise control if this eventuality presents.

4. The documentation of participation in continuing education programs does not insure improvement of the participant's competence with respect to the health care he renders.

5. Non-members of the society are not affected either positively or adversely.

6. The demand for the traditional type of programs, which heretofore have not been based on the objective determination of needs, will be increased mainly to satisfy the requirement for a number of hours of participation. This may deter the development of more objective methods for determining educational needs.

Arguments in favor of this resolution were as follows:

1. The establishing of such requirements will reassure the public that the medical profession is, in fact,

striving to improve its capabilities and that it will identify and penalize those physicians who do not make the effort to improve themselves.

2. As a result, the medical society will reaffirm itself as a scholarly order of professionals, truly interested and dedicated to increasing its collective knowledge and skill. Thus, the society would reassert its identity with excellence, both within and outside of the profession.
3. By establishing such requirements for physicians, the stage is set for the development of more objective methods for determining educational needs.
4. Closer understanding and collaboration between academic medicine and the practicing physician will surely develop.

A second resolution was approved:

> "That the American Medical Association endorse the development and use of the problem-oriented medical record system, or other appropriate system, as an objective means to improve the quality of medical care."

In the ensuing discussion of this resolution, all three workshop groups agreed that the adoption of the problem-oriented record would provide the basis for improving medical care through a systematic approach to patient problems on a continuing and sequential basis. Standardization of the record facilitates continual self-education, and the means to minimize the errors of omission or commission. Properly implemented, the incomplete or erroneous management of a patient's problem is easily identified and called to the attention of the physician who then has the opportunity to modify his plan and educating himself in so doing. As such, the problem-oriented record continually motivates the physician to improve his knowledge with regard to the problem at hand; the education is always relevant.

It was pointed out that a systematic approach to the medical record facilitates medical audit, peer review, and influences the quality of consultation. Additionally, adaptability of system to computerization enhances the potential for epidemiological studies and other investigative research. The system imposes a standard discipline on the physician who must record in an orderly fashion that data which is available from the patient, the physical examination, and the diagnostic studies. An orderly plan must be set down for each problem identified. In itself, the problem-oriented record is a strong motivating force for self-education and self-improvement.

In the third workshop session, it was strongly recommended by many participants that the American Medical Association assume a more critical attitude regarding the continuing medical education programs which it accredits.

In the ensuing discussion, it was the feeling that although the AMA's efforts in accrediting programs were laudible, the Association should insist that the sponsors of courses provide for more participant critique and appropriate evaluation of content. Several participants expressed the opinion that if this were done, a strong motivating force for physicians to continue to participate in such courses would result. It was also suggested that the faculty and students should exchange their expectations of the educational experience for the mutual benefit of all concerned. If more stringent controls are exercised in the courses, the stature of the AMA's accreditation program will improve and establish without question its reliability as a guideline for potential students.

Other points of discussion included the following:

1. The participants in each workshop agreed that the profession must recognize that medical practice and medical education are intimately interrelated. Therefore, methods must be provided to the practicing physician to utilize his work time dealing with patient problems as the primary source of his education. A careful definition of the problems of his patients and utilizing of all available sources to resolve these problems should constitute the backbone of his continuing education.

2. It was also felt by all groups that one of the most valuable means of medical education was the consultation. It should be stressed to practicing physicians that consultation should be utilized more extensively.

3. The role of peer review in medical audit was emphasized as a powerful motivating force influencing physicians to improve their quality of care. Properly instituted and controlled, potential punitive aspects of such mechanisms can be minimized.

4. Medical care facility providers, insurers, governmental agencies and other third parties concerned with health care payments must be convinced by demonstration that quality medical care is less expensive than poor medical care. (This has been demonstrated by a number of studies.) The financial support of those activities which are shown to improve the quality of care should then naturally follow. A strong motivating force, therefore, is cost benefit which results from the implementation of methods suggested above.

5. It was noted that roughly 10% of practitioners will always insure professional competence throughout their careers regardless of outside influence. On the other end of the scale, approximately the same

percentage remain uninfluenced by any outside stimulation and seemingly take no steps to enhance their professional abilities. The large middle majority of physicians require assistance in the maintenance of motivation throughout their career. Methods which increase his effectiveness professionally, considering time and cost, will be most easily accepted by the practitioner who often has the will but not the way to maintain, let alone improve, his competence.

6. Considerable comment was offered on the role of the medical school in establishing motivational patterns in students. It was noted that in the latter years of medical school, and certainly in the consecutive years of postgraduate training, the motivational drive seems to decrease. Goals are related to the passings of examinations, in medical school, followed by the national boards and the specialty board exams. Having received ultimate credentials, the young physician seems to have lost in part his motivation to continue his education. While no specific solutions are forthcoming from our group, it was suggested that medical schools with well-functioning departments of continuing medical education, sensitive to the needs of their constituents, should play a role in the establishing of habit patterns in students designed to serve them throughout their careers. By demonstration and example, such departments can lead the student into establishing his own disciplines of life-long education.

Moderator: George W. Welsh, M.D., Vermont
Recorder: James A. Kronenberg, Oregon

WORKSHOP ON EVALUATION

Your workshop on evaluation has considered a number of basic thoughts and opinions, as follows:

1. Evaluation of patient care in the hospital and outside the hospital, and evaluation of continuing education, are closely related - and, in fact, are regarded by many as one inseparable discipline.

2. While a hospital might be the most accessible arena for evaluation of patient care and continuing education, medical societies should be developing evaluation models; and should be providing the stimulus for effective evaluation programs.

3. On of today's most critical needs, therefore, is a firm commitment on the part of state medical societies to develop and support continuing education. Most state societies have defaulted badly in this regard.

4. Too often, professional medical educators have not been on the firing line with respect to the need for, and participation in, evaluation of patient care. The ideal situation exists when a doctor cannot tell whether he is engaged in patient care or in self-education.

5. Unless medical societies and others get away from financial considerations as the primary reason for auditing and evaluating, there can be no hope for the desired outcome, namely, improved patient care.

6. If therefore, there is not a mechanism for proper auditing of patient care as a basis for educational programming, policing outcomes will result to an undesirable degree, and in undesirable forms.

7. Errors of omission, which can also be disclosed by audits or other means, may be of as much concern as anything else to the patient, and should be given consideration in any evaluation program.

8. Criteria for quality patient care needs ultimately to be set clearly at the local level.

9. In this connection, each medical community needs to determine its own criteria, even if all or part of such criteria might prove to be less than ideal. The point to be emphasized is that a start toward setting evaluation criteria must be made, and the local level is the place to begin.

10. Stimulus from medical societies toward development of criteria and evaluation techniques will need to follow different patterns in different areas. In other words, different packages of approaches are needed, and such approaches may need to be different in the same community at different times.

11. While patient care criteria, evaluation efforts and education programming decisions need finally to be made at the local level, expert help and consultation from the outside should be sought and used.

In light of the points listed above, the Workshop on Evaluation adopted the following resolution for consideration by the Second National Conference of State Medical Association Representatives on Continuing Medical Education, and for whatever additional action and consideration might be proper:

> "Quality of care evaluation is an educational tool which identifies needs for individual and group education. This must be its immediate goal. Any other use must be secondary. Such evaluation must therefore, be the prime commitment of the professional society, whether the society's function is national, state, county, institutional or specialty.
>
> "It is a fact that any organization responsible for evaluation will control the quality of medical care. It also is recognized that quality of care definitions represent a dynamic concept into which the health team, including the patient, will have significant and repeated contributions.
>
> "Therefore, be it resolved, in each state, that the state medical society should provide overall coordination-leadership of continuing education and quality of medical care evaluation, and must control and support this effort in a formal, official and legal way, as an expression of the policy of the American Medical Association."

Moderators: Robert L. Evans, M.D., Pennsylvania
Norman S. Stearns, M.D., Massachusetts
Recorder: Charles R. Lewis, West Virginia

WORKSHOP ON ORGANIZATION AND METHODS

The participants felt that the organization and methodology of continuing medical education must relate to the paramount goal - quality of patient care. It was felt that there is indeed a need for the organization that represents most physicians and diversity of interest, the AMA, to play a role in the achievement of this goal. In outline form below are listed some potential functions that would help further continuing medical educational efforts towards this end:

(1) "COORDINATOR"
  (a) Meetings of these organizations -
    Allied Health Professions (?)
    American Hospital Association
    American Medical Association
    Association of American Medical Clinics
    Directors of Medical Education (AHME)
    HEW
    Medical Schools (AAMC)
    National Academy of Sciences
    Regional Medical Programs
    Specialty Societies
    State Medical Associations
    U.S. Public Health Service
    Voluntary Health Agencies

  (b) Purposes
    Exchange of ideas
    Avoid duplication of efforts
    Identify educational problems and decide who will settle them
    Define the goals - "quality of patient care"
    Collaboration of efforts (e.g., sharing of DME's by hospitals, sharing of programs by states)
    Collaboration of educational activities

(2) "CLEARINGHOUSE"
  Medical educational efforts of the organizations listed under (1) (encourage cooperation and help avoid duplication)

(3) "CATALYZER"
  (a) Physician's Recognition Award
  (b) Statements on the needs of physicians for and the importance of continuing medical education
  (c) Teams to help set up continuing medical education at the local level

(4) "PUBLICIZER AND INFORMATION DISSEMINATOR"
  (a) News Releases
  (b) Editorial in *JAMA*
  (c) Continuing Education Section in *JAMA*
  (d) More frequent listing of courses in *JAMA*

- (e) *Continuing Medical Education Newsletter*
- (f) Dissemination of information on other state societies and institutions' continuing medical education efforts

(5) "PURVEYOR"
- (a) Scientific Meetings
- (b) Courses of instructional techniques for setting up and arranging continuing education programs

(6) "PROMOTER"
- (a) Funding aid
  - (i) Directly (matching funds?)
  - (ii) Sources of funds available
- (b) Staffing aid
  - (i) Direct
  - (ii) Courses on organization and staffing
- (c) Materials - list of availables
- (d) Medical Schools - to have departments of continuing education or postgraduate education

(7) "EVALUATOR"
- (a) Accreditation
- (b) Evaluation of results and effectivenss of continuing education

(8) "RESEARCHER"
- (a) What does the doctor do?
- (b) What does the doctor need in terms of education?
- (c) See 7 above

STATE MEDICAL SOCIETY ORGANIZATIONAL STEPS
(see many of AMA functions above)

(1) Resources
- (a) Funding
- (b) Staff
- (c) Materials

(2) Identify educational needs
- (a) Surveys of doctors
- (b) Summaries of activities available
- (c) "Physician Profile"
- (d) Peer review - office, hospital
- (e) Self-assessment

(3) Establish programs to meet (1) above
- (a) Formal
- (b) Informal

(4) Evaluate result of programs - behavioral change

Moderator: Ronald L. Kaye, M.D., California
Recorder: Perry L. Smithers, Illinois

WORKSHOP ON FINANCING

The objectives of this workshop were to explore the various techniques that are presently being used to finance continuing medical education, to share experiences, and to explore possible new sources of financing.

At the completion of the three workshop sessions, a few significant characteristics appeared. First, it became apparent that financing of programs was not the primary problem in continuing medical education today. Not only was this voiced several times, but the relatively small number of attendance to the meetings would seem to indicate that this was not of primary interest to the participants. Perhaps the remainder of the report will also shed some light on the reasons why financing is not considered at this point in time to be a primary problem.

One of the major obstacles which appeared to impair the reaching of concrete conclusions is that it is difficult to determine how to finance continuing medical education without the problems being clearly defined. The absence of definite direction in continuing medical education makes it difficult to develop a financial structure to support it. Problems such as peer review, self-assessment, recertification, and relicensure are examples of some concepts which were put forward. It was concluded that until these methods are more fully developed, financing of these techniques will be very difficult. Each of these types of approaches to continuing medical education demands slightly different types of financing. Determination of financial responsibility depends to some degree on the particular approach that is being taken.

Another statement which repeatedly appeared was that money should be found to define the problem first. Examples were given several times of people having money available for continuing medical education, but not knowing how to use it. Generally, the participants felt that once the specific problems in continuing education were defined and techniques developed to solve the problems, then money could be found to finance the educational projects. This leads several of us to the conclusion that perhaps more of the available money should be directed toward defining the problem and toward structuring continuing medical education rather than spending it on specific projects in continuing medical education.

Each workshop group was asked to make comments regarding the financial responsibility of the state medical societies in continuing medical education. The general consensus indicates that one of the primary roles of the state medical associations is the organization and correlation of continuing medical education in the geographic sphere in which that medical association has influence. The medical association should be prepared to provide administrative support to its component societies and to hospital staffs who need direction in development of continuing medical education programs. The state medical society seems to be in a position where it can make judgments regarding the appropriate expenditure of funds for continuing medical education in the state.

It was further felt that state medical societies could work with medical schools within their state to give them specific direction regarding development of continuing medical education programs. Furthermore, it was felt appropriate and proper that medical societies provide some degree of financial support to medical schools in this effort. This however, is dependent upon a clear-cut commitment by the medical schools to provide continuing education to physicians.

The workshops were asked to approach the problem of the moral and financial responsibility of various groups in society toward continuing medical education. It was agreed that it was the valid concern of these following listed groups. This does not imply that other groups might not be concerned also.

1. The consumer. It is felt that the consumer would be the direct recipient of improved patient care, and, as such, must share in the cost of continuing medical education. This is most likely to be realized whenever hospitals provide money for continuing medical education. The hospitals naturally will get their funds from the consumers. It was pointed out that hospitals should probably allocate from one to three percent of their annual budget toward continuing medical education of the medical staff.

2. Federal government. It was felt that federal government programs represent the responsibility of all the members of society as a whole. Improved medical care is a legitimate concern of the taxpayer. It is felt that continuing medical education is a legitimate expenditure of tax monies in order to obtain improved patient care. Funds that are presently allocated through regional medical programs, specific U.S. Public Health Service grants, and multiple other grants and loans are the current techniques and probably will remain the most important techniques of distribution of the common wealth toward continuing medical education.

3. Medical schools. Medical schools have a clear obligation to society for the development and maintenance of continuing medical education programs. Land Grant colleges, of course, represent tax money from the state. It is felt that continuing medical education is a part of the state's responsibility in education of the people. It was expressed that the separation of undergraduate, graduate, and continuing medical education is an artificial one.

4. Individual physician. The individual physician clearly has a financial responsibility towards his own education. He may pay for this by direct payment for educational experiences, through his state medical association, through his specialty societies, and through taxation.

5. Voluntary agencies, foundations, drug companies, insurance companies, etc. This variegated group of people have some degree of interest in health care. This degree of interest varies with the agency and its goals. If any of its goals include a serious attempt to improve the level of patient care in the country, then it has a responsibility, financially and morally, to aid in continuing medical education.

6. Organized medical associations, national, state, local, and specialty. The role of the medical society was alluded to previously. The medical society can play a further role through its political influence on state legislatures and the Congress of the United States by presenting legitimate arguments regarding the allocation of public funds to aid continuing medical education. Specialty societies can set standards and can aid in evaluating educational programs as well as serve as sources of faculty for teaching.

Thus, there are many agencies and organizations which have some degree of financial responsibility. The percentage or degree of involvement financially can not be accurately predicted at this time. Most of the participants agreed that the eventual techniques will involve mainly public funds and payment by consumer. It was expressed that medical societies could well provide seed money for continuing education, but since the continuing costs of medical education will be prohibitive for any one group, the financing will most likely be a blend of several of the sources suggested.

We feel that at least two specific recommendations can be made:

1. More money should presently be spent on the definition of the problems which need solution, and establishment of a system which will solve those problems. Presently a great deal of money is being spent in developing educational techniques without an adequately structured system in which to apply those techniques.

2. State medical societies, with the direction of the American Medical Association should make significant attempts at this time to develop the administrative potential of tapping internal and external financial resources and directing the expenditure of these monies more efficiently for effective continuing medical education.

Moderator: Paul R. Young, M.D., Missouri
Recorder: Louis W. Crist, Pennsylvania

WORKSHOP ON THE ROLE OF THE STATE MEDICAL ASSOCIATION IN CONTINUING MEDICAL EDUCATION

All three meetings of Workshop No. 5 "The Role of the State Medical Association in Continuing Medical Education" were well attended and practically all who attended actively participated in the discussions. The Moderator was furnished some 21 questions he could put forth in case of any show of apathy; however, he was given no opportunity to try out even one of these questions.

There was unity expressed by all discussants that state societies have a very important role and a definite responsibility and are logical agents for the development and stimulation of programs in continuing medical education for their members. In accomplishing this, the state society should utilize the talents and the programs of specialty societies, medical schools, RMP, Voluntary Health Agencies, and every other educational organization or facility available in the developing of a coordinated educational program that would meet the needs of its members, as well as those physicians practicing in the state who are not members of the society. After all, the purpose of continuing medical education is good patient care. State societies must recognize that such programs are primarily for the benefit of the people and only secondarily for their physician members.

In order to develop any worthwhile program of continuing medical education, it is incumbent that the physicians' educational needs be determined. Examination does not necessarily reflect either their competency or incompetency. Only evaluation of behavior in the physician's practice will truly reveal the weak spots in one's medical acumen. If possible, the state society must develop programs to make these determinations before developing the educational program itself. The continuation of such evaluation of care rendered by its members will also be a yardstick in testing the effectiveness of the educational programs developed and pointing out where changes need to be made.

However, this does not mean that the state society should be the locus of all evaluation and educational programs. The most logical site for these activities is the medical staff. The role of the state society, in addition to providing some educational programs itself, is to stimulate, assist, and guide the hospitals in their carrying out this responsibility. Admittedly some hospitals are too small, too remote, to do this job effectively themselves. In such situations, the state society must take a more active and direct role in implementing the programs. There must be a pluralistic approach to the state-wide program dependent upon the varying environments within the state.

The utilization of a hospital as a site for community medical education does not mean that the program shall be directed solely towards in-hospital care. Hospitals that accept this responsibility must orient their programs to meet the educational needs for both in-hospital and out-of-hospital (office and home) care. This necessitates each hospital evaluating the office and home care rendered by the physician in their community.

There is no unanimity in regard to making evidence of participation in continuing medical education as requirement for state society membership. Oregon, Arizona and Pennsylvania have adopted these principles. California has developed a strong voluntary program of recognition for continuing education.

It was pointed out that a good doctor will participate voluntarily in continuing medical education. However, stronger evidence furnished by the American Medical Association and the state societies in the form of a concrete commitment and a placing of high priority on a long term basis is sorely needed if we wish to make our programs more affective. On the other hand, it was pointed out that quite a number of physicians are not even aware of their educational deficiences.

It was the unanimous opinion that licensure and relicensure is the responsibility of the state boards of education and licensure. Likewise, there was expression of opinion that the state boards should consider competency in relicensure. However, there was no support for examination by the state boards for such relicensure. Some states felt that state boards could depend upon the continuing medical educational program sponsored by the state society as evidence of competency. Others could not support this view. A warning was made that standards for relicensure should not be so high that will deprive one-physician-areas of needed health services.

One interesting suggestion was made that the American Medical Association should develop alternative models illustrating the responsibilities and activities of the AMA, state society, local society, specialty society, hospital and individual physicians in continuing medical education. State societies could then select and/or modify that model which best meets their respective needs.

The repeated requests for stronger commitment on the part of the AMA and state societies for high priority assignment of continuing medical education among the programs of the AMA and state societies indicates to your Moderator a desire that this National Conference on Continuing Medical Education requests the Board of Trustees Committee on Continuing Medical Education to recommend to the Board of Trustees of the AMA that it place a high "priority" on a long-term basis on continuing education for physicians, that this be done in the form of adequate financing, staffing and programming, and that the Board of Trustees of the AMA use all means at its disposal to persuade state societies to do likewise.

Moderator: James Z. Appel, M.D., Pennsylvania
Recorder: Max R. Mehlhaff, California

LIST OF PARTICIPANTS

ALABAMA
Arthur M. Freeman, M.D., 614-622 Medical Arts Building, Birmingham, 35205
Walter B. Frommeyer, Jr., M.D., University of Alabama, 1919 Seventh Avenue, S., Birmingham, 35233
Margaret S. Klapper, M.D., Medical College of Alabama, Division of Continuing Medical Education, 1919 Seventh Avenue, S., Birmingham, 35233

ARIZONA
Robert E. T. Stark, M.D., 1033 E. McDowell Road, Phoenix, 85006

CALIFORNIA
E. Grey Dimond, M.D., Box C, Rancho Santa Fe, 92067
Ronald L. Kaye, M.D., Palo Alto Medical Clinic, 300 Homer Avenue, Palo Alto, 94301
Mr. Max R. Mehlhaff, California Medical Association, 693 Sutter Street, San Francisco 94102
Donald W. Petit, M.D., University of Southern California School of Medicine, 1 West Bay Street, Alhambra, 91801
C. John Tupper, M.D., University of California, Davis School of Medicine, Davis, 95616

COLORADO
Marvin E. Johnson, M.D., St. Joseph Hospital, Denver, 80218
Mr. Larry H. Miller, Colorado Medical Society, 1809 E. 18th Street, Denver, 80218

CONNECTICUT
C. D. Davis, M.D., 333 Cedar Street, New Haven, 06510
Dr. Charles Polivy, 60 Gillett Street, Hartford, 06105

DELAWARE
E. Wayne Martz, M.D., Wilmington Medical Center, P.O. Box 1668, Wilmington, 19899

DISTRICT OF COLUMBIA
Hugh T. Carmichael, M.D., American Psychiatric Association, 1700 18th Street, N.W., 20009
K. Albert Harden, M.D., Freedmen's Hospital, 6th and Bryant Streets, N.W., 20001
William E. Matory, M.D., Howard University College of Medicine, Continuing Medical Education, 6th and Bryant Streets, N.W., 20001
Kingsley M. Stevens, M.D., Continuing Medical Education, 52-H Veterans Administration, 20420

FLORIDA
Francis C. Coleman, M.D., 4600 N. Habana Avenue, Suite 23, Tampa, 33614
Richard C. Dever, M.D., 329 Ingraham Building, Miami, 33131
Max Michael, Jr., M.D., Jacksonville Hospitals Educational Program, 2000 Jefferson Street, Jacksonville, 32206
Mr. Eugene L. Nixon, Florida Medical Association, P.O. Box 2411, Jacksonville, 32203

ILLINOIS

Richard Allyn, M.D., 107 S. 5th Street, Springfield, 62701
Merle S. Bacastow, M.D., American Hospital Association, 840 N. Lake Shore Drive, Chicago, 60611
Dean R. Bordeaux, M.D., 2421 W. Rohmann Avenue, Peoria, 61604
J. Ernest Breed, M.D., 55 E. Washington, Chicago, 60602
Dr. Herschel Browns, 360 N. Michigan Avenue, Chicago, 60601
Bradford W. Claxton, M.Ed., American College of Chest Physicians, 112 E. Chestnut Street, Chicago, 60611
Peter S. Rosi, M.D., Department IE/MS, Technical Institute, Northwestern University, Evanston, 60201
Mr. Perry L. Smithers, Illinois State Medical Society, 360 N. Michigan Avenue, Chicago, 60601
Freeman H. Vaughn, Hospital Research and Educational Trust, 840 N. Lake Shore Drive, Chicago, 60611
Harold A. Zintel, M.D., American College of Surgeons, 55 E. Erie Street, Chicago, 60611

IOWA

Richard M. Caplan, M.D., University Hospitals, Iowa City, 52240
Dr. L. J. O'Brien, 1005 2nd Avenue, N., Fort Dodge, 50501
Miss Tina Preftakes, Iowa Medical Society, 1001 Grand Avenue, West Des Moines, 50265

KANSAS

Russell J. Eilers, M.D., University of Kansas Medical Center, 39th and Rainbow Boulevard, Kansas City, 66103
William J. Reals, M.D., St. Joseph Hospital, 3400 E. Grand Avenue, Wichita, 67218

LOUISIANA

Rafael C. Sanchez, M.D., LSU School of Medicine, 1542 Tulane Avenue, Room 231, New Orleans, 70112

MAINE

Richard T. Chamberlin, M.D., Thayer Hospital, Waterville, 04901
Manu Chatterjee, M.D., 56 Baribeau Drive, Brunswick, 04011
J. H. P. Garnett, M.D., Maine Regional Medical Program, Augusta

MARYLAND

John C. Bish, Ed.D., American College of Cardiology, 9650 Rockville Pike, Bethesda, 20014
Henry A. Briele, M.D., Medical Center, Salisbury, 21801
Dr. Ruth M. Davis, National Library of Medicine, 8600 Rockville Pike, Bethesda, 20014
Ephraim T. Lisansky, M.D., 6804 Park Heights Avenue, Baltimore, 21215
Arnold C. Ratner, M.D., 10401 Old Georgetown Road, Bethesda, 20014

MASSACHUSETTS

George J. Robertson, M.D., Tufts University School of Medicine, 171 Harrison Avenue, Boston, 02111

MASSACHUSETTS (cont.)	Norman S. Stearns, M.D., Postgraduate Medical Institute, Boston, 02215
MINNESOTA	William R. Fifer, M.D., University of Minnesota Division, Northlands RMP, 4959 Excelsior Boulevard, Minneapolis, 55416
MISSISSIPPI	Dennis E. Ward, M.D., Route 1. Corinth, 38834
MISSOURI	Dr. Gail I. Bank, Office of Continuing Medical Education, M-175 University Medical Center, Columbia, 65201 Paul R. Young, M.D., Research Hospital, Meyer Boulevard at Prospect, Kansas City, 64132
NEBRASKA	C. A. McWhorter, M.D., 701 Doctors Building, Omaha, 68105 R. C. Rosenlof, M.D., 5 West 31st, Kearney, 68847
NEW MEXICO	George M. Boyden, M.D., Presbyterian Hospital, Albuquerque, 87106 R. C. Derbyshire, M.D., 227 E. Palace Avenue, Santa Fe, 97501
NEW YORK	Marvin L. Bloom, M.D., 680 Lafayette Avenue, Buffalo, 14222 William Nelson, M.D., Albany Medical College, Albany, 12208 George F. Reed, M.D., 705 E. Adams Street, Syracuse, 13210
NORTH CAROLINA	Ron W. Davis, Ed.D., Association for North Carolina Regional Medical Program, P.O. Box 8248, Durham, 27704 Louis Shaffner, M.D., Bowman Gray School of Medicine, Winston-Salem, 27103
NORTH DAKOTA	W. L. Macauley, M.D., Fargo Clinic, Fargo, 58102
OHIO	Glidden L. Brooks, M.D., P.O. Box 6190, Toledo, 43614
OKLAHOMA	Dale Groom, M.D., 800 N.E. 13th Street, Oklahoma City, 73104
OREGON	W. D. Harrison, M.D., 4960 S.W. Washington, Beaverton, 97005 Mr. James A. Kronenberg, Oregon Medical Association, 2164 S.W. Park Place, Portland, 97205 Merle Pennington, M.D., Sherwood, 97140 George Schunk, M.D., 115 Mission, Salem, 97302
PENNSYLVANIA	James Z. Appel, M.D., 305 N. Duke Street, Lancaster, 17602 Mr. Louis W. Crist, American College of Physicians, 4200 Pine Street, Philadelphia, 19104 Robert L. Evans, M.D., York Hospital, York,17403

PENNSYLVANIA (cont.)	Miss Velma L. McMaster, Pennsylvania Medical Society 20 Erford Road, Lemoyne, 17043 Edward C. Rosenow, Jr., M.D., American College of Physicians, 4200 Pine Street, Philadelphia, 19104
PUERTO RICO	Dr. E. S. Colon-Rivera, 969 Americo Miranda Avenue, Reparto Metropolitano, Rio Piedras, 00921 Dr. Aviel Diaz, 19 Baldomar Street, Urb. Munoz Rivera, Guaynabo, 00657
RHODE ISLAND	Howard S. Browne, Jr., M.D., 24 Kay Street, Newport, 02840
SOUTH CAROLINA	William A. Klauber, M.D., Self Memorial Hospital, Greenwood, 29646
SOUTH DAKOTA	James C. Larson, M.D., 506 1st Avenue, S.E., Watertown, 57201
TENNESSEE	Bland W. Cannon, M.D., Medical Center Plaza, Suite 609, 910 Madison Avenue, Memphis, 38103 Ben D. Hall, M.D., 115 W. Fairview, Johnson City, 37601 Mr. Hank Holderfield, Tennessee Medical Association, 112 Louise Avenue, Nashville, 37203 Tom E. Nesbitt, M.D., 1921 Hayes Street, Nashville, 37203 John Saffold, M.D., 605 Walnut Street, Knoxville, 37920 John B. Thomison, M.D., 2100 West End Avenue, Nashville, 37203
TEXAS	Stanley W. Olson, M.D., Southwest Foundation for Research and Education, P.O. Box 28147, San Antonio, 78228 Grant Taylor, M.D., University of Texas Graduate School of Biomedical Science, P.O. Box 20367, Houston, 77025
UTAH	Russell M. Nelson, M.D., 42 S. 5th East Street, Salt Lake City, 84102
VERMONT	Dr. John C. Lantman, Main Street, Williston, 05495 George W. Welsh, III, M.D., Given Medical Building, University of Vermont, Burlington, 05401
VIRGINIA	Dr. John C. Hortenstine, Winchester Memorial Hospital, Winchester, 22601
WASHINGTON	William O. Robertson, M.D., University of Washington School of Medicine, Seattle, 98105 Thomas F. Sheehy, M.D., 1012 Cobb Medical Center, Seattle, 98121
WEST VIRGINIA	Daniel Hamaty, M.D., 4701 MacCorkle Avenue, S.E., Charleston Mr. Charles R. Lewis, P.O. Box 1031, Charleston, 25324 Pat A. Tuckwiller, M.D., 25-28 Brooks Medical Building, Charleston

WISCONSIN	Sigurd E. Sivertson, M.D., Department of Postgraduate Medical Education, University of Wisconsin, 307 North Charter Street, Madison, 53706
AMA STAFF	Miss J. Heather Carr, Department of Continuing Medical Education Miss Dorothy M. Duncan, Division of Medical Education Rutledge W. Howard, M.D., Department of Continuing Medical Education Clarke W. Mangun, Jr., M.D., Department of Continuing Medical Education C. H. William Ruhe, M.D., Division of Medical Education T. F. Zimmerman, Ph.D., Division of Medical Education

----

ERIC Clearinghouse
APR 1 8 1972
on Adult Education